Advance Care Directive Form

Government of South Australia

By completing this Advance Care Directive you can choose to:

1. Appoint one or more Substitute Decision-Makers and/or
2. Write down your values and wishes to guide decisions about your future health care, end of life, living arrangements and other personal matters and/or
3. Write down health care you do not want in particular circumstances.

Part 1

You must fill in this Part.

Part 1: Personal details

Name: _____

(Full name of person giving Advance Care Directive)

Address: _____

Ph: _____ ☎ Date of birth: ____/____/_____

Part 2a

Your Substitute Decision-Maker fills in this section and must sign before you do.

You must provide the Substitute Decision-Maker with the Substitute Decision-Maker Guidelines prior to completing this section.

Your Substitute Decision-Maker fills in this section. →

If you did not fill in any of this Part please draw a large "Z" across the blank section.

Only fill in Part 2a if you want to appoint one or more Substitute Decision-Makers.

Part 2a: Appointing Substitute Decision-Makers

I appoint: _____

(Name of appointed Substitute Decision-Maker)

Address: _____

Ph: _____ ☎ Date of birth: ____/____/_____

I, _____

(Name of appointed Substitute Decision-Maker)

am over 18 years old, and I understand and accept my role and the responsibilities of being a Substitute Decision-Maker as set out in the Substitute Decision-Maker Guidelines.

Signed: _____ Date: ____/____/_____

(Signature of appointed Substitute Decision-Maker)

Part 2a (continued over page)

Your initial:_____

Witness initial:_____

Date:___/___/___

Certification statement or JP stamp

See page 15 for suggested certification statement

Part 2a (cont.)

Your second Substitute Decision-Maker fills in this section and must sign before you do.

If you did not appoint a second or third Substitute Decision-Maker please draw a large "Z" across any blank sections.

AND

I appoint: _____
(Name of appointed Substitute Decision-Maker)

Address: _____

Ph: _____ ☎ Date of birth: ___ / ___ / _____

I, _____
(Name of appointed Substitute Decision-Maker)

am over 18 years old, and I understand and accept my role and the responsibilities of being a Substitute Decision-Maker as set out in the Substitute Decision-Maker Guidelines.

Signed: _____ Date: ___ / ____/ ____
(Signature of appointed Substitute Decision-Maker)

I appoint: _____
(Name of appointed Substitute Decision-Maker)

Address: _____

Ph: _____ ☎ Date of birth: ___ / ___ / _____

I, _____
(Name of appointed Substitute Decision-Maker)

am over 18 years old, and I understand and accept my role and the responsibilities of being a Substitute Decision-Maker as set out in the Substitute Decision-Maker Guidelines.

Signed: _____ Date: ___ / ____/ ____
(Signature of appointed Substitute Decision-Maker)

Part 2b

If you do not specify, your Substitute Decision-Makers will be able to make decisions either together or separately.

For more information see page 1 of the Guide.

Part 2b: Conditions of Appointment

If you have appointed one or more Substitute Decision-Makers do you want them to make decisions together or separately? Please specify below:

_____

_____

_____

_____

Your initial:_____

Witness initial:_____ Date:____/____/_____

Part 3

In this part you can write:

a) What is important to you

For more information and suggested statements see page 2 of the Guide.

b) Outcomes of care you wish to avoid

For more information and suggested statements see page 3 of the Guide.

c) Health care you prefer

For more information and suggested statements see page 4 of the Guide.

Please draw a large "Z" across any blank sections.

Part 3: What is important to me – my values and wishes:

a) When decisions are being made for me, I want people to consider the following:

b) Outcomes of care I wish to avoid (what I don't want to happen to me):
(See Part 4 for binding refusals of health care)

c) Health care I prefer:

Part 3 continued on next page

Your initial:_____

Witness initial:_____ Date:____/____/_____

Part 3 (cont.)

In this part you can write:

d) Where you wish to live

For more information and suggested statements see page 5 of the Guide.

e) Other personal arrangements

For more information and suggested statements see page 5 of the Guide.

f) Dying wishes

For more information and suggested statements see page 6 of the Guide.

Please draw a large "Z" across any blank sections.

Part 3: What is important to me – my values and wishes:

d) Where I wish to live:

e) Other personal arrangements:

f) Dying wishes:

Your initial:_____

Witness initial:_____ Date:____/____/_____

Part 4

For more information about writing down your refusal(s) of health care and some suggested statements see page 7 of the Guide.

If you did not fill in this Part please draw a large "Z" across the blank section.

Part 4: Binding refusals of health care

I make the following binding refusal/s of particular health care:
(If you are indicating health care you do not want, you must state when and in what circumstances it will apply as your refusal(s) must be followed, pursuant to section 19 of the Act, if relevant and applicable).

_____

_____

_____

_____

_____

_____

Part 5

If you did not use an Interpreter please draw a large "Z" across the blank section.

Do not complete Part 5 unless an Interpreter was used.

Part 5: Interpreter statement

I _____ certify the following:

(Full name of Interpreter)

- The Advance Care Directive Information Statement was given and translated by me to:

_____

(name of person giving Advance Care Directive)

- In my opinion he/she appeared to understand the information given.
- The information recorded in this Advance Care Directive Form was translated by me and accurately reproduces in English the original information and instructions of the person.

Ph:_____ ☎

Address: _____

Signed: _____ Date: ___ / ___ /_____

(Signature of Interpreter)

Your initial:_____	Witness initial:_____ Date:____/____/_____

Part 6

You must sign this Form in front of an **independent witness.**

Only an independent authorised witness can sign your Advance Care Directive

The Information for Witnesses guide should be included with this Form. The witness must read it before signing the Form.

Your independent authorised witness signs and completes this part of the Form.

Space is provided if a person, due to an injury, illness or disability, needs to execute the document in another way such as by placing a "mark" on the document, or if a representative needs to sign on their behalf.

Part 6: Witnessing my Advance Care Directive

I,_____

(Full name of person giving this Advance Care Directive)

do hereby give this Advance Care Directive of my own free will.

I certify that I was given the Advance Care Directive Information Statement and that I understand the information contained in the Statement.

Signed: _____ Date: ___ / ___ / _____

(Signature of the person giving this Advance Care Directive)

Witness statement

I,_____ have

(Full name of Witness)

read and understood the Information for Witnesses guide and certify that I gave: _____

(Full name of person giving this Advance Care Directive)

the Advance Care Directive Information Statement.

In my opinion he/she appeared to understand the information and explanation given and did not appear to be acting under any form of duress or coercion.

He/She signed this Advance Care Directive in my presence.

_____

(Authorised witness category)

Ph:_____ ☎

Signed: _____ Date: ___ / ___ / _____

(Signature of Witness)

Space for extra execution statement:_____

_____

_____

_____

_____

Your initial:_____

Witness initial:_____ Date:____/____/_____