בס"ד

BEIT RAFAEL
HERE FOR YOU
בית רפאל ביקור חולים

M: 0421 408 522
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A: 28 TALBOT AVENUE
ST KILDA EAST 3183
VIC AUSTRALIA

Advance (Health) Care Directive for Adults

prepared by

BEIT RAFAEL BENEVOLENT INSTITUTION

for the

VICTORIAN JEWISH COMMUNITY

BEIT RAFAEL PTY. LTD. ACN: 155 515 594
TRUSTEE FOR THE **BEIT RAFAEL BENEVOLENT INSTITUTION** ABN: 12 450 469 547
ENDORSED BY THE ATO AS A PUBLIC BENEFIT INSTITUTION WITH DEDUCTIBLE GIFT RECIPIENT STATUS

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The first Jewish "Advance (Health) Care Directive" made its appearance in Genesis (47:29,30), when Jacob, nearing the end of his life, implored Joseph to bury him with his forefathers.

"… if I have found grace… bury me not, I pray thee, in Egypt," Jacob declared. "But I will lie with my fathers, and thou shalt carry me up from Egypt and bury me in their burying-place. And Joseph said I will do in accordance with thy words".

The way we care for those who are seriously ill has evolved since Jacob spoke with Joseph.

Medical technology grows more sophisticated each day, and with that comes the ability to intervene, cure disease, mend bodies and prolong life. Each of us needs to consider whether we desire extraordinary measures to prolong our life and if so, which of those we are willing to accept. These interventions, however, are not always in our best interests.

Victorian Government legislation allows adults to document their preferences for future medical treatment, should they lose decision-making capacity. A person can record general statements about their health values to guide future medical treatment decisions, as well as record specific instructions refusing, or consenting to, different types of treatment. This legally binding personalized guide assures that your wishes will be followed even if you are unable to articulate them. It seeks to capture the totality of your health values and instructions to be applied in various unforeseen circumstances as to what is important and what is not important to you excluding the questions surrounding 'end of life', colloquially referred to as "turning off the switch".

This Advance HealthCare Directive provides a range of options. For example, you may indicate whether you wish to be intubated or not; you may indicate whether you wish to donate organs or not; etc. etc. Your Doctor and/or Solicitor or Rabbi can assist with your decision-making process. The Directive is drawn up in a manner that is acceptable under the strictest interpretations of Jewish law and has been reviewed and approved by Rabbi M. Z. Gutnick (Head of Melbourne Beth Din).

We are grateful to Rabbi Weiner of Cedar Sinai Hospital (Los Angeles) for permission to incorporate elements of his Advance HealthCare Directive within the Victorian Government Advance Care Directive for Adults.

We presume that you have written your Will. This Advance (Health) Care Directive is equally important, if perhaps not more so, and we hope that after discussion with your family and doctor/s, you complete this and ensure signed copies are held by your family / doctor/s / solicitor. It should also be 'uploaded' to:- www.myhealthrecord.gov.au

BEIT RAFAEL Benevolent Institution has prepared the attached Directive and is pleased to provide this for the benefit of our Community. Should there be any questions do not hesitate to contact us via email:- admin@beitrafael.org OR tel:- 0421 408-522

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This Advance Care Directive for Adults requires careful consideration. We suggest that as you read through this Document, jot down your thoughts and any questions you wish to discuss with your Family and Doctor/s.

After reading this Document and understanding its overall aim, in the first instance this Directive should then be reviewed and discussed with your General Practitioner / Specialist Doctor/s, together with (as applicable) your spouse / primary carer / adult child.

Keep in mind that through this Document you are communicating to your Medical Treatment Decision Maker, who is legally required to consider your Instructions and Values, the information which will guide/help this individual to make the decisions you would want.

What matters in life varies from person to person. Things that make your life worth living may include family, friends, religious beliefs, interests, independence etc.

Therefore, what matters most to you will affect the decisions you make about your medical treatment. This Document will inform your Medical Treatment Decision Maker as to what 'the quality of life' means to you.

Do you wish to live as long as possible, whatever it takes? For example,

- would you be prepared to permanently rely on a breathing machine to keep you alive ?
- do you wish to live when you no longer have control of your bladder and bowels ?
- do you wish to undergo haemodialysis ?
- do you wish to undergo major surgery which may not produce beneficial long-term benefits ?
- do you wish to be resuscitated ?

OR is it the quality of your life which is most important to you ?

If remaining independent is important then indicate what you mean by this. For example,

- being able to make decisions for yourself
- living in your own home
- being able to take care of your personal grooming
- remaining mobile

An Advance Care Directive is often referred to as a 'living will'. As such we recommend that it be reviewed and updated every two years.

MTPD001

Advance care directive for adults

made under the *Medical Treatment Planning and Decisions Act 2016* (Vic.)

Reset Form | Save Form | Print Form

For patient record purposes, health services can affix UR number, patient name and date of birth here

Any advance care directive that you have previously made under this Act is automatically revoked (cancelled) when you complete this advance care directive.

This form is designed for adults to complete using the *Instructions for completing the advance care directive form* document.

THIS DOCUMENT ALWAYS TO BE PRINTED IN COLOUR.

Part 1: Personal details

You must fill in your full name, date of birth and address. A phone number is optional.

Your full name:	
Date of birth: (dd/mm/yyyy)	
Address:	
Phone number:	

If you have no current health problems, cross out this section.

My **current** major health problems are:

It is helpful to know if you have completed an Advance Statement in relation to a mental illness.

Mark with an X if the statement below is relevant to you.

I **have** completed an Advance Statement under the *Mental Health Act 2014* (Vic.).	☐

VICTORIA State Government

MTPD001

Advance care directive for adults (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

Advance care directive of: (insert your full name)	

Part 2: Values directive

Your medical treatment decision maker is legally required to first consider your values directive when making decisions about your medical treatment.

Identify who your medical treatment decision maker is and discuss your preferences and values with them. You can appoint someone using the *Appointment of a medical treatment decision maker* form. Refer to Part 2 of the instructions for more information.

You may complete all, some, or none of the sections.

a) What matters most in my life:
(What does living well mean to you?)

In Part 2 you can write your values and preferences for your medical treatment.
Refer to Part 2 a) of the instructions.

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Draw a circle around the number in each table to indicate your values and preferences.

PHYSICAL AND BODILY CONSIDERATIONS

Remaining fully independent in all of my daily activities (e.g. feed myself, bathe myself, dress myself)

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Being in control of my bodily functions (e.g. bowels, bladder)

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Being as comfortable (without pain) as possible

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

BEIT RAFAEL

Draw a circle around the number in each table to indicate your values and preferences.

Being able to walk

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Being able to get out of bed

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Being able to move around without someone else's help

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Being able to go outside

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

COGNITIVE CONSIDERATIONS

Being able to take part in decision-making about my healthcare

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Being conscious (minimally aware)

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

INTERACTIVE, SOCIAL AND COMMUNITY CONSIDERATIONS

Talking to other people

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Draw a circle around the number in each table to indicate your values and preferences.

Communicating in some way with other people

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Having my family or friends (not strangers) take care of me

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Contributing to my family's wellbeing

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Knowing that I am not a burden to others

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Having privacy when I want it

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Notes:

MTPD001

Advance care directive for adults (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

b) What worries me most about my future:

Refer to Part 2 b) of the instructions.

c) For me, unacceptable outcomes of medical treatment after illness or injury are:
(For example, loss of independence, high-level care or not being able to recognise people or communicate)

Part 2 c) of the instructions includes a table with examples of health outcomes to help you complete this section.

BEIT RAFAEL

Draw a circle around the number in each table to indicate your values and preferences.

Living outside of a healthcare facility (such as a hospital or nursing home)

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

BEIT RAFAEL

Draw a circle around the number in each table to indicate your values and preferences.

END OF LIFE CONSIDERATIONS

Living free of being permanently connected to mechanical life support

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Not dying alone

Not Important		Somewhat Important		Extremely Important
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Willing to endure much pain to have life prolonged

Disagree		Somewhat Agree		Strongly Agree
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Willing to endure much pain to remain alive for a family occasion (such as a wedding or Bar/Bat Mitzvah)

Disagree		Somewhat Agree		Strongly Agree
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Willing to accept aggressive pain medications even if that means I will not be awake and will be unable to participate in decision-making about my healthcare

Disagree		Somewhat Agree		Strongly Agree
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

OTHER CONSIDERATIONS

As a patient, in general I would like to know:

Nothing about my condition and my treatment		Only the basics about my condition and my treatment		All the details about my condition and my treatment
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Draw a circle around the number in each table to indicate your values and preferences.

If I have a terminal illness, I would prefer to:

Not know any details or how quickly it is progressing				Know all details and my doctor's best estimation for how long I have to live
☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

My life would be worth living, and therefore I would want my life to be prolonged as long as possible, under the following circumstances:

If my medical practitioner believes that I do not have a reasonable chance of recovering to the above quality of life, I would not want the following procedures or medical interventions initiated:

MTPD001

Advance care directive for adults (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

Advance care directive of: (insert your full name)	

Part 2: Values directive (cont.)

d) Other things I would like known are:

Refer to Part 2 d) of the instructions.

Things you can include about your values and preferences are:

- spiritual, religious, or cultural requirements
- your preferred place of care
- treatment with prescription pharmaceuticals (medicine)
- treatment for mental illness
- medical research procedures.

e) Other people I would like involved in discussions about my care:

Refer to Part 2 e) of the instructions.

f) If I am nearing death the following things would be important to me:

Refer to Part 2 f) of the instructions.

Things to consider include: persons present, spiritual care, customs or cultural beliefs met, music or photos that are important.

Select **one** statement below and mark your response with an X.

I **am** willing to be considered for organ and tissue donation, and recognise that medical interventions may be necessary for donation to take place. *Refer page 13/17*	☐
I **am not** willing to be considered for organ and tissue donation.	☐

Advance care directive for adults

As a Jew, it is my desire, and I hereby direct, that all decision-making about my healthcare be done in accordance with Jewish law and custom.

To determine the requirements of Jewish law and custom, I further direct my Medical Treatment Decision Maker to consult with the following Rabbi:

Rabbi

Name: _____

Phone Number(s): _____

Email Address (if known): _____

Street Address (if known): _____

City, State, Post Code (if known): _____

If such Rabbi is unable, unwilling or unavailable to provide such consultation and guidance, I direct my Medical Treatment Decision Maker to consult with the following Rabbi or Rabbi referred by by the institution or organization.

Alternate Rabbi/Institution

Name: _____

Name of Institution/Organization: _____

Phone Number(s): _____

Email Address (if known): _____

Street Address (if known): _____

City, State, Post Code (if known): _____

If such institution or organization is unable, unwilling or unavailable to make such a referral, or if the Rabbi referred by such institution or organization is unable, unwilling or unavailable to provide such guidance, then I ask my Medical Treatment Decision Maker to consult with a Rabbi whose guidance on issues of Jewish law and custom my Medical Treatment Decision Maker in good faith believes I would respect and follow.

What matters to me at the end of life is that I be given the following; oxygen, hydration, nutrition, unless medically contraindicated. As well, ……

Please complete the sentence below by initialing either option 1 or option 2:

I would like my Medical Treatment Decision Maker to begin participating in decision-making about my healthcare…

Option 1

…only when my medical practitioner determines that I am unable to express my own goals, values and preferences.

SIGNATURE HERE

_____

(Initial Here)

Option 2

…from this time forward, even if I am still able to speak for myself.

SIGNATURE HERE

_____

(Initial Here)

You may have medical practitioners involved in your care who understand your goals, values and preferences. If you would like them to be involved in discussions regarding your condition and treatment options, please list their names and contact information below.

Name of Medical Practitioner: _____

Phone Number(s) (if known): _____

Email Address (if known): _____

Name of Medical Practitioner: _____

Phone Number(s) (if known): _____

Email Address (if known): _____

Name of Medical Practitioner: _____

Phone Number(s) (if known): _____

Email Address (if known): _____

Should you wish to be an Organ Donor please indicate your instruction by initialling Option 1 or Option 2.

I agree to donate my organs for life-saving transplantation - not for research - upon the onset of the following:

Option 1

Irreversible cessation of autonomous breathing, that is confirmed by the determination of brain death. (This is the position of the Chief Rabbinate of Israel.)

All preparations for transplant must be done in consultation with my family-approved Rabbi.

All medical procedures must be done with utmost care, respect, and be minimally invasive to the cadaver. The only organs are _____

SIGNATURE HERE

_____

(Initial Here)

Option 2

Irreversible cessation of heartbeat. (From a medical perspective this limits the number of organs that may be recovered.)

All preparations for transplant must be done in consultation with my family-approved Rabbi.

All medical procedures must be done with utmost care, respect, and be minimally invasive to the cadaver. The only organs are _____

SIGNATURE HERE

_____

(Initial Here)

My Wishes for After I Die

All decisions concerning the handling and disposition of my body and preparation for burial are to be made pursuant to Jewish law and custom as determined by my designated Rabbi. Prior to contacting my designated Rabbi, unless there is prior specified authorization by the Rabbi, it is my desire, and I hereby direct, that no post-mortem procedure be performed on my body (e.g. subject to certain limited exceptions, Jewish law generally prohibits the performance of any autopsy).

I have the following wishes regarding funeral and burial arrangements:

MTPD001

Advance care directive for adults (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

Advance care directive of: (insert your full name)	

Part 3: Instructional directive

This instructional directive is legally binding and communicates your medical treatment decision(s) directly to your health practitioner(s). It is recommended that you consult a medical practitioner if you choose to complete this instructional directive.

- Your instructional directive will only be used if you do not have decision-making capacity to make a medical treatment decision.
- Your medical treatment decisions in this instructional directive take effect as if you had consented to, or refused to, begin or continue medical treatment.
- If any of your statements are unclear or uncertain in particular circumstances, it will become a values directive.
- In some limited circumstances set out in the Act, a health practitioner may not be required to comply with your instructional directive.

Cross out this page if you do not want to consent to or refuse future medical treatment.

Refer to Part 3 of the instructions for more information on how to complete your instructional directive.

Keep in mind:

- you should include details about the circumstances in which you consent to or refuse treatment
- health practitioners can only offer treatment that is medically appropriate
- in an end-of-life care situation, certain medical interventions may be required for organ and tissue donation to take place.

a) I consent to the following medical treatment:
(Specify the medical treatment and the circumstances)

b) I refuse the following medical treatment:
(Specify the medical treatment and the circumstances)

MTPD001

Advance care directive for adults (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

Advance care directive of: (insert your full name)	

Part 4: Expiry date (optional)

Only complete this part if you want this advance care directive to have an expiry date. Refer to Part 4 of the instructions.

This advance care directive expires on: (dd/mm/yyyy)	

Part 5: Witnessing

You must sign in front of two adult witnesses.

One witness must be a registered medical practitioner.

Neither witness can be a person that you have appointed as your medical treatment decision maker.

Refer to Part 5 of the instructions if someone else is signing on your behalf.

Signature of person giving this directive (you sign here)

SIGNATURE HERE

Each witness certifies that:

- at the time of signing the document, the person giving this advance care directive appeared to have decision-making capacity in relation to each statement in the directive and appeared to understand the nature and effect of each statement in the directive; and
- the person appeared to freely and voluntarily sign the document; and
- the person signed the document in my presence and in the presence of the second witness; and
- I am not an appointed medical treatment decision maker of the person.

Witness 1 – Registered medical practitioner

A registered medical practitioner must complete this part of the form.

Full name of registered medical practitioner:

Qualification and AHPRA number of registered medical practitioner:

Signature of registered medical practitioner: Date: (dd/mm/yyyy)

SIGNATURE HERE

Witness 2 – Adult witness

Another adult witness must complete this part of the form.

Full name of adult witness:

Signature of adult witness: Date: (dd/mm/yyyy)

SIGNATURE HERE

Advance care directive for adults

MTPD001

Advance care directive for adults (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

Advance care directive of: (insert your full name)	

If an interpreter is present when this document is witnessed

If an interpreter is present at the time the document is witnessed, they complete this section immediately after the document is witnessed.

Name of interpreter:

If accredited with the National Accreditation Authority

NAATI number:	

I am competent to interpret from English into the following language:

I provided a true and correct interpretation to facilitate the witnessing of the document.

Signature of interpreter: Date: (dd/mm/yyyy)

SIGNATURE HERE	

Part 6: Interpreter statement

If an interpreter assisted in the preparation of this document

If an interpreter helped you to prepare this document, they complete this section.

They can fill in this section before the document is witnessed or at the time the document is witnessed.

Refer to Part 6 of the instructions.

Name of interpreter:

If accredited with the National Accreditation Authority

NAATI number:	

I am competent to interpret from English into the following language:

When I interpreted into this language the person appeared to understand the language used in the document.

Signature of interpreter: Date: (dd/mm/yyyy)

SIGNATURE HERE	

You have reached the end of this form.

It is recommended that you **review your advance care directive every two years**, or whenever there is a change in your personal or medical situation.

- Please keep your original advance care directive safe and accessible for when it is needed.
- Ensure that your medical treatment decision maker (if any) has read and understood its contents.
- Your advance care directive can be uploaded on MyHealth Record and should be shared with your medical treatment decision maker and relevant health practitioner(s) / health service(s).

MTPD002

Appointment of medical treatment decision maker

made under the *Medical Treatment Planning and Decisions Act 2016* (Vic.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

Your medical treatment decision maker has legal authority to make medical treatment decisions on your behalf, if you do not have decision-making capacity to make the decision.

Your medical treatment decision maker is the first person you list below who is reasonably available, and willing and able to make the decision. Only adults can appoint a medical treatment decision maker.

Part 1: Personal details

Before you start, read the checklist of steps with this form.

You must fill in your full name, date of birth and address. A phone number is optional.

Your full name:	
Date of birth: (dd/mm/yyyy)	
Address:	
Phone number:	

Part 2: Medical treatment decision maker details

This form allows you to appoint up to two people. To appoint more people, use the long version of this form.

I **revoke** any other previous appointment of a medical treatment decision maker however described.

I **appoint** as my medical treatment decision maker(s):

Medical treatment decision maker 1

Fill in the details of your first medical treatment decision maker here.

Full name:	
Date of birth: (dd/mm/yyyy)	
Address:	
Phone number:	

Medical treatment decision maker 2

Fill in the details of your second medical treatment decision maker here.

Cross out this section if you are not appointing a second medical treatment decision maker.

Full name:	
Date of birth: (dd/mm/yyyy)	
Address:	
Phone number:	

VICTORIA State Government

MTPD002

Appointment of medical treatment decision maker (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

Appointment by: (insert your full name)	

Part 3: Any limitations or conditions (optional)

Cross out if not including limitations or conditions.

Part 4: Witnessing

You must sign in front of two adult witnesses.

One witness must be a registered medical practitioner or able to witness affidavits. See justice.vic.gov.au/affidavit for list.

Neither witness can be an appointed medical treatment decision maker for you.

Refer to the checklist if someone else is signing on your behalf.

Signature of person making this appointment (you sign here)

SIGNATURE HERE

Each witness certifies that:

- at the time of signing the document, the person making this appointment appears to have decision-making capacity and appears to understand the nature and consequences of making the appointment and revoking any previous appointment; and
- at the time of signing the document, the person making this appointment appeared to freely and voluntarily sign the document; and
- the person signed the document in my presence and in the presence of a second witness; and
- I am not the person's medical treatment decision maker under this appointment.

Witness 1 – Authorised witness

A registered medical practitioner or someone able to witness affidavits must complete this section.

Full name of authorised witness:

Qualification of authorised witness:

Signature of authorised witness:	Date: (dd/mm/yyyy)
SIGNATURE HERE	

Witness 2 – Adult witness

Another adult witness must complete this section.

Full name of adult witness:

Signature of adult witness:	Date: (dd/mm/yyyy)
SIGNATURE HERE	

MTPD002

Appointment of medical treatment decision maker (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

Appointment by: (insert your full name)	

If an interpreter is present when this document is witnessed

If an interpreter is present at the time the document is witnessed, they complete this section immediately after the document is witnessed.

Name of interpreter:

If accredited with the National Accreditation Authority

NAATI number:	

I am competent to interpret from English into the following language:

I provided a true and correct interpretation to facilitate the witnessing of the document.

Signature of interpreter: SIGNATURE HERE	Date: (dd/mm/yyyy)

Part 5: Interpreter statement

If an interpreter assisted in the preparation of this document

If an interpreter assisted you in preparing this document, the interpreter completes this part.

Cross out Part 5 if not relevant.

I interpreted in the following language:

When I interpreted into this language the person appeared to understand the language used in the document.

Name of interpreter:

NAATI number (if accredited):	

Signature of interpreter: SIGNATURE HERE	Date: (dd/mm/yyyy)

Appointment of medical treatment decision maker

MTPD002

Appointment of medical treatment decision maker (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

Appointment by: (insert your full name)	

Part 6: Statement of acceptance

Each medical treatment decision maker you appoint must read the statement of acceptance and sign in front of an adult witness.

Your first medical treatment decision maker must read this statement of acceptance and sign in front of an adult witness.

Medical treatment decision maker 1

I accept my appointment as medical treatment decision maker and state that:

- I understand the obligations of an appointed medical treatment decision maker; and
- I undertake to act in accordance with any known preferences and values of the person making the appointment; and
- I undertake to promote the personal and social wellbeing of the person making the appointment, having regard to the need to respect the person's individuality; and
- I have read and understand any advance care directive that the person has given before, or at the same time as, this appointment.

Name of medical treatment decision maker:

Signature of medical treatment decision maker: SIGNATURE HERE	Date: (dd/mm/yyyy)

Witness completes this section.

I certify that I witnessed the signing of this statement of acceptance.

Name of adult witness:

Signature of adult witness: SIGNATURE HERE	Date: (dd/mm/yyyy)

MTPD002

Appointment of medical treatment decision maker (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

Appointment by: (insert your full name)	

Part 6: Statement of acceptance (cont.)

Medical treatment decision maker 2

If you appoint a second medical treatment decision maker, they must read this statement of acceptance and sign in front of an adult witness.

I accept my appointment as medical treatment decision maker and state that:

- I understand the obligations of an appointed medical treatment decision maker; and
- I undertake to act in accordance with any known preferences and values of the person making the appointment; and
- I undertake to promote the personal and social wellbeing of the person making the appointment, having regard to the need to respect the person's individuality; and
- I have read and understand any advance care directive that the person has given before, or at the same time as, this appointment.

Name of medical treatment decision maker:

Signature of medical treatment decision maker: SIGNATURE HERE	Date: (dd/mm/yyyy)

Witness completes this section.

I certify that I witnessed the signing of this statement of acceptance.

Name of adult witness:

Signature of adult witness: SIGNATURE HERE	Date: (dd/mm/yyyy)

You have reached the end of this form.

- Please keep your original 'Appointment of medical treatment decision maker' form safe and accessible for when it is needed.
- It is recommended your medical treatment decision maker has read and understood the contents of your advance care directive (if any).
- Your 'Appointment of medical treatment decision maker' form and advance care directive can be uploaded on MyHealth Record and it is recommended copies be shared with your appointed medical treatment decision maker and relevant health practitioner(s) / health service(s).

Appointment of medical treatment decision maker