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.

SAMPLE ONLY

Part 1

You must fill in this Part.

Part 1: Personal details

Name: Serena Primrose

(Full name of person giving Advance Care Directive)

Date of birth: 21 / 1 / 1952

Part 2a

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

Your Substitute Decision-Maker fills in this section. →

Part 2a: Appointing a substitute decision-maker(s)

I appoint: Amelia Sherlock

(Name of appointed Substitute Decision-Maker)

Ph: 8000 8000 ☎ Date of birth: 2 / 7 / 1968

I, Amelia Sherlock

(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: A Sherlock Date: 1 / 7 / 2014

(Signature of appointed Substitute Decision-Maker)

AND

I appoint: ____________________

(Name of appointed Substitute Decision-Maker)

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)

Your Substitute Decision-Maker fills in this section. →

If you did not fill in any of this Part please draw a line diagonally across it.

Part 2a (continued over page)

Your initial SP Witness initial JW

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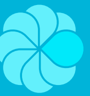


Part 2a (cont.)

Your Substitute Decision-Maker fills in this section. →

If you did not appoint a third Substitute Decision-Maker please draw a line diagonally across this Part.

AND

I appoint: ____

(Name of appointed Substitute Decision-Maker)

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.

You can also write down here what type of decisions (health care, residential or personal) your Substitute Decision-Makers can make.

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

If you did not fill in Part 2b please draw a line diagonally across it.

Part 2b: Conditions of Appointment

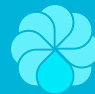
If you have appointed one or more Substitute Decision-Makers would you want them to make decisions together or separately?
Please specify below:

Amelia, please speak to my sister
Louise when you make any serious
decisions about my health care.

SAMPLE ONLY

Your initial SP Witness initial JW

Advance Care Directive Form



Part 3

In this part you can write:

- **What is important to you**
- **Outcomes that you would want to avoid**
- **Health care you prefer**
- **Where you wish to live**
- **Other personal arrangements**
- **Dying wishes**

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

If you did not fill in this Part please draw a line diagonally across this Part.

For more information about writing down your refusal(s) of health care and some suggested statements see page 8 of the Guide.

If you did not fill in this Part please draw a line diagonally across this Part.

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

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

What is important to me: my family + friends are very important to me. Being independent + having a dog is also very important..
Outcomes I wish to avoid:• If I have a mental health episode I would prefer to be given my usual treatment at home + not be put in care.
• If I am unable to recognise my family + friends + can't communicate, I do not want any health care to prolong my life.
My dying wishes: If I am dying I want to be in a comfortable environment surrounded by my family and friends.
• If I can, I would like to say goodbye to my family before I die.

I make the following binding refusal/s of particular health care:

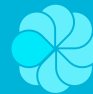
(If you are indicating refusal of health care, you must state when and in what circumstances it will apply as your refusal(s) must be followed, pursuant to section 19 of the Act, if relevant and applicable).

If I have a terminal illness, I do not want any life sustaining treatment. Please just keep me comfortable and pain free until I die.

Your initial SP Witness initial JW

SAMPLE ONLY

Advance Care Directive Form



Part 4

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

Only an independent authorised witness can sign your Advance Care Directive

Information for witnesses is included with this Form.

Part 4: Giving my Advance Care Directive

I, Serena Primrose
(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: S Primrose Date: 1 / 7 / 2014
(Signature of the person giving this Advance Care Directive)

Witness statement

I, Jasper Westall certify that:
(Full name of Witness)

I gave: Serena Primrose
(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.

Ph: 8111 8111 ☎ Lawyer
(Occupation of Witness)

Signed: J Westall Date: 1 / 7 / 2014
(Signature of Witness)

SAMPLE ONLY

Part 5

Do not complete this Part unless an Interpreter was used.

If you did not use an Interpreter please draw a line diagonally across this Part.

Part 5: Interpreter statement

I, ______ certify that:
(Full name of Interpreter)

The Advance Care Directive Information Statement was given through 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 accurately reproduces in English the original information and instructions of the person.

Ph: ______ ☎

Signed: ______ Date: ___ / ___ / ___
(Signature of Interpreter)

Form approved by the Minister for Health pursuant to the Advance Care Directives Act 2013 (SA)

Your initial SP Witness initial JW