

Let Me Decide

Health and Personal Care Directive

New South Wales Version

1. Introduction

In this Directive I am stating my wishes for my health and personal care should the time ever come when I am not able to communicate because of illness or injury. This Directive should never be used if I am able to decide for myself. It must never be substituted for my judgement if I can make these decisions.

If the time comes when I am unable to make these decisions, I would like this Directive to be followed and respected. Please do everything necessary to keep me comfortable and free of pain. Even though I may have indicated that I do not want certain treatments, I recognise that these may be necessary to keep me comfortable.

I understand that my choices may be overridden if a treatment is necessary to maintain my comfort.

I have thought about and discussed my decision with my family, friends and family doctor. In an emergency, please contact my “person responsible” or my family doctor listed over. If these people are not available, then please do as I have requested in this Directive.

I understand that I can revise this Directive at anytime and that it should be reviewed once a year, after an illness or if there is a change in my health. If I need to update the Directive I can fill in a new form otherwise I can endorse the contents by signing again on the last page.

Person(s) Responsible (contact details on page 4 of this document)

I, _____ (*print name*), acknowledge that:

① _____ (*print name*) is my person responsible because they are my (*please circle*):

- i. Enduring guardian, who possesses the legal authority to act, either (*please circle*):
(a) separately; or (b) jointly with _____ (*print name*); or
- ii. Spouse / defacto, with whom I have a close, continuing relationship; or
- iii. Unpaid carer who provides (or previously provided) support to me; or
- iv. Relative / friend with whom I have a close personal relationship

If my “person/s responsible” indicated above is/are not available for any reason, declines in writing to exercise their functions, or a medical practitioner or qualified person certifies in writing that the person/s responsible’ is/are not capable for carrying out the functions, then I acknowledge that:

② _____ (*print name*) becomes my person responsible, according to the hierarchy set by the Guardianship Act, because they are my (*please circle*):

- i. Spouse / defacto, with whom I have a close, continuing relationship; or
- ii. Unpaid carer who provides (or previously provided) support to me; or
- iii. Relative / friend with whom I have a close personal relationship.

2. Definitions

A. Loss of functioning that is NOT acceptable AND NOT reversible

An *unacceptable* and *irreversible* loss in my ability to function may result from:

- a) An illness or injury that is *not* reversible and that leaves me with a loss in ability to function that consider to be *not* acceptable.

B. Loss of functioning that IS acceptable AND/OR IS reversible

An acceptable and/or reversible loss in my ability to function may result from either:

- b) A life threatening illness or injury that is reversible. This is curable, meaning that losses in my ability to function are not permanent. *OR*
- c) An illness or injury that is *not* reversible, but that leaves losses in my ability to function that I consider to be acceptable.

C. Cardiac Arrest (CPR)

CPR

Use cardiac massage with mouth-to mouth breathing ; may also include intravenous lines, electric shocks to the heart (defibrillators), tubes in throat to lungs (endotracheal tubes).

NO CPR

Make no attempt to resuscitate.

D. Feeding

Basic

Spoon-fed with a regular diet. Give all fluids by mouth that can be tolerated, but make no attempt to feed by special diets, intravenous fluids or tubes.

Supplemental

Give supplements or special diets (eg. high calorie, fat or protein supplements).

Intravenous

Give nutrients (water, salt, carbohydrate protein and fat) by intravenous infusions.

Tube

Use tube feeding. There are two main types:

Nasogastric Tube: a soft plastic tube passed through the nose or mouth into the stomach.

Gastrostomy Tube: a soft plastic tube passed directly into the stomach through the skin over the abdomen.

E. Levels of Care

Palliative Care

Keep me warm, dry and pain free. Do not transfer to hospital unless absolutely necessary. Only give measures that enhance comfort or minimise pain (eg. morphine for pain). Intravenous line started only if it improves comfort (eg. for dehydration). No x-rays, blood tests or antibiotics unless they are given to improve comfort.

Limited Care (includes Palliative)

May or may not transfer to hospital. Intravenous therapy may be appropriate. Antibiotics should be used sparingly. A trial of appropriate drugs may be used. No invasive procedures (eg. surgery). Do not transfer to Intensive Care Unit.

Surgical Care (includes Limited)

Transfer to acute care hospital (where patient may be evaluated). Emergency surgery if necessary. Do not admit to Intensive Care Unit. Do not ventilate (except during and after surgery ie. Tube down throat and connected with machine).

Intensive Care (includes Surgical)

Transfer to acute care hospital without hesitation. Admit to Intensive Care Unit if necessary. Ventilator if necessary. Insert central line (ie. main arteries for fluids when other veins collapse). Provide surgery, biopsies, all life support systems and transplant surgery. Do everything possible to maintain life.

*****TO THE MEDICAL OFFICER*****

3. Health and Personal Care

Personal Statement.

I would consider an unacceptable level of functioning for me to include:



so,

**If my loss of functioning is NOT acceptable AND NOT reversible
(Definition A.) then please treat me as I have indicated below.**

<i>Cardiac Arrest (Definition C.)</i>	<i>Life threatening Illness (Definition E.)</i>	<i>Feeding (Definition D.)</i>
<i>CPR No CPR</i>	<i>Intensive Surgical Limited Palliative</i>	<i>Tube Intravenous Supplemental Basic</i>

(Write your choice in the box provided)

**If my loss of functioning IS acceptable AND/OR IS reversible,
(Definition B.) then please treat me as I have indicated below**

<i>Cardiac Arrest (Definition C.)</i>	<i>Life threatening Illness (Definition E.)</i>	<i>Feeding (Definition D.)</i>
<i>CPR No CPR</i>	<i>Intensive Surgical Limited Palliative</i>	<i>Tube Intravenous Supplemental Basic</i>

(Write your choice in the box provided)

I would agree to the following procedures (write yes or no)

Blood transfusion _____
Organ transplant _____

In the event of my death, I consent to the following procedures
(write yes or no)

Organ donation _____
Post Mortem _____
Cremation _____

4. Signatures

NOTE: This Directive can either be completed on its own, or in conjunction with Enduring Guardianship forms, available from the NSW Guardianship Tribunal. Phone: 1800 463 928 (toll free) or (02) 9555 8500



Person Completing the Directive

I, _____ (*print name*)

Of address: _____

am voluntarily completing this Advance Care Directive document of my own free will on this date: _____

Signed: _____

Person(s) Responsible

I/we have read, understood and agree to act in accordance with the contents of this Directive:

- 1). Name _____
Signature _____
Date _____
Address _____
Ph: (hm) _____ (wk) _____

- 2). Name _____
Signature _____
Date _____
Address _____
Ph: (hm) _____ (wk) _____

- 3). Name _____
Signature _____
Date _____
Address _____
Ph: (hm) _____ (wk) _____

Enduring Guardian/s

If I have an enduring guardian/s, they were appointed on the date: _____

And the document is held at: _____

General Practitioner

Name _____
Signature _____
Date _____
Address _____
Ph: (hm) _____ (wk) _____

Witness

I am the witness to this Directive. I verify that _____ (*print name of the person completing Directive*) signed this Directive on this date: _____ of his or her own free will, without threats or offered inducements. I am not a relative of the person completing this Directive nor of the person/s responsible and I am not involved in the person's medical treatment.

Name _____
Signature _____
Date _____
Address _____
Ph: (hm) _____ (wk) _____

Updating this Directive (*in 12 months time*)

If, after reviewing this document in 12 months time, I wish to endorse the contents, I do so by signing below:

Signature _____ Date _____