

Name: .....

Date of birth:        /        /

Address: .....

This statement sets out clearly what treatments I would, and would not, consent to under the conditions outlined below. I am making this statement willingly because there may be some time in the future when I am unable to express these things myself, because of illness or injury. If this situation occurs, I want my substitute decision-makers and any treating doctors to respect my wishes and follow the directions I have given. I accept that some of the treatments listed below may be considered medically futile in end-stage disease and may not be offered as a treatment option.

In terms of your views about your quality of life in the future, at what point would you want the goals of medical care to switch from intensive treatments aimed at prolonging life to focusing on palliative or comfort care? Some people describe this in terms such as the irreversible loss of ability to recognise people, feed themselves, walk, talk etc.

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If you reach that point in the future where:

- your quality of life is very low as defined in the previous question;
- your underlying medical condition is irreversible, i.e. it will not get better;
- you are not able to express your wishes at the time;

AND

a) Your heart suddenly stopped, would you consent to having cardiopulmonary resuscitation (CPR) and life support (including defibrillation to restart your heart or putting a tube into your lungs to support your breathing)?

Yes         No

b) You could no longer safely take food or fluid by mouth, would you consent to being fed indefinitely by a tube into your stomach?

Yes         No

c) You were unconscious and unable to breathe on your own, would you consent to being supported indefinitely on a mechanical ventilator?

Yes         No

d) You developed renal failure, would you consent to being supported indefinitely by kidney dialysis?

Yes         No

e) Your medical condition deteriorated, would you want treatments that primarily focused on providing comfort and dignity rather than treatments that primarily focused on extending your life at any cost?

Yes         No

f) If any of the above interventions have been commenced but there is no chance that your quality of life as defined above will improve, would you consent to the interventions being stopped?

Yes  No

g) Are there any of the above – or any other – medical treatments that you would definitely refuse under all circumstances?

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h) Are there any other directions you want to give to medical and other staff that may be looking after you at the end of life?

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If you complete this worksheet, it is strongly recommended that you sign and date it as well as have at least one person witness your signature. They should also provide their contact details. Although there is no specific legal requirement for this, it is a good practice in case there is any doubt in the future about the validity of the document.

Signature: ..... Date: .....

**Witness 1:**

Name: ..... Signature: ..... Date: .....

Address: .....

Phone number: .....

**Witness 2:**

Name: ..... Signature: ..... Date: .....

Address: .....

Phone number: .....

Dates this worksheet was reviewed by person completing it to check its currency:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This worksheet is one of a series of worksheets that are part of the START2TALK program administered by Alzheimer's Australia. Full information can be found at [www.start2talk.org.au](http://www.start2talk.org.au)

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