



## STATEMENT OF CHOICES

This statement of choices can be used with the Natural Death Act prescribed form and will help to guide future medical decisions ONLY when you lose the ability to make or communicate your medical treatment decisions yourself.

I, ..... of .....  
(Your name) (Your address)

am of sound mind, and have read and understand the importance of this document. I have also had the document explained to me and had all my questions answered to my satisfaction. I request that my stated choices recorded below, are respected by my family, medical enduring power of attorney (if appointed), and by my doctors. In addition I request that they respect my beliefs and values.

I appoint ..... of ..... as my medical enduring power of attorney to make all decisions about any and all medical treatments should I lose the capacity to make these decisions myself. This may mean making decisions at the end-of-life such as withdrawing or commencing medical treatment. For the purposes of this power, "medical treatment" means the carrying out of an operation, or the administration of a drug or other substance, or any other medical procedure, including palliative care.

### PLANS FOR LIFE PROLONGING TREATMENTS. ( 3 options )

Initial the option(s) you want in the box of the relevant section. You can write specific requests in the spaces beneath each option.

1. I would like life prolonging treatments to be commenced and continued, including Cardio – Pulmonary Resuscitation (CPR), while they are medically appropriate and remain in my best interests.  
 .....  
.....  
.....  
.....

2. If I am acutely ill and unable to communicate responsively with my family and friends, and it is reasonably certain that I will not recover, I want to be allowed to die naturally and be cared for with dignity. I do not want to be kept alive by extraordinary or overly burdensome measures that might be used to prolong my life. (eg Cardio – Pulmonary Resuscitation). If any of these treatments have been started, I request that they be discontinued. However I do want palliative care that includes medications and other treatments to alleviate suffering and keep me comfortable and to be offered something to eat and drink.  
 .....  
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3. I understand that if I do not sign any of the above, that decisions regarding life prolonging treatments will be made by my medical enduring power of attorney (if appointed) or other persons responsible for making my medical decisions, in consultation with my treating doctors.



**OTHER REQUESTS WITH REGARD TO MY MEDICAL CARE.**

Eg. Such as circumstances in which you do or do not want a particular treatment.

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**OTHER POINTS THAT ARE IMPORTANT TO ME**

If you have other end-of-life wishes, eg. organ or body donation, you may wish to attach your documentation to this plan. NB. It is important to register as a donor and discuss your wishes with your next of kin / family.

I ask that my decision maker include the following persons in my health care decisions if there is time:

.....  
.....  
.....

If I am nearing death, I want the following (list the things that are important to you):

.....  
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.....

If I am nearing death and cannot speak please give my friends and family the following message:

.....  
.....  
.....

If there is not enough room to write all your requests and wishes, please attach further pages as necessary. All additional pages need to be signed, dated and witnessed.

I ..... hereby declare that the information completed above is a true record of my wishes on this date.

Signature.....Date .....

Witness signature .....Date .....

Witness name .....Relationship.....