

SOUTH AUSTRALIAN ADVANCE CARE PLAN: Information Sheet FORM 1

Advance care planning in South Australia is being promoted by the Respecting Patient Choices Program. This program is about the promotion of autonomy and dignity and not about euthanasia or suicide. You have the right to make decisions about your health care, now and for the future. Medical treatment should only be given with your fully informed consent and you have the right to refuse treatment. If, in the future, you become unable to express your choices for treatment, your doctors and family/friends may not know what you would want. An Advance Care Plan gives you the opportunity to record, ahead of time, your choices. An Advance Care Plan **ONLY** comes into effect if you are no longer considered legally capable of making your own decisions about your medical treatment.

The four ways to record your choices in an Advance Care Plan are:

1. Appointing a Medical Power of Attorney (MPA called your Medical Agent)
2. Completing an Anticipatory Direction
3. Appointing an Enduring Power of Guardianship
4. Documenting your wishes in the Statement of Choices

The first three are types of legal advance directives. The Statement of Choices is not a legal document but is a record of your wishes that can be included in your medical file.

Before completing the Advance Care Plan, take time to read the following information carefully. It is important that you discuss your goals, values and beliefs and the content of this Advance Care Plan with the person whom you wish to appoint as your Medical Agent. It is important that you involve your Medical Agent, and you discuss your Advance Care Plan together so that they understand and respect your choices.

1. Medical Power of Attorney

This is a legal document that enables you to appoint another person to make medical treatment decisions on your behalf. This person, referred to as your Medical Agent, can make health care decisions on your behalf **only** if you are not able to make or communicate decisions.

Your Medical Agent must be at least 18 years of age and mentally competent to make decisions. You may choose to appoint more than one Medical Agent. If the first is not available, the second is to be consulted, if the first and second are not available, the third is to be consulted and so on. You cannot appoint joint Medical Agents and only one Medical Agent can act at a time. You appoint them in the order in which you would want them approached. Your Medical Agent is **not** authorised to make non-medical (e.g. financial) decisions for you.

When selecting someone to be your Medical Agent, it is important to choose someone who:

- You trust and who knows you well
- Is willing to accept the role and respect your views and values
- Is able to make decisions under circumstances that may be difficult or stressful.

Often a family member is a good choice as a Medical Agent, but not always. Make sure that you choose someone who will closely follow what you want and will be a good advocate for you.

Your MPA must be witnessed by an authorised witness, which means a justice of the peace, a commissioner for taking affidavits in the Supreme Court (most solicitors), a member of the clergy or a registered pharmacist. It can also be witnessed by a bank manager or a police officer who is officially appointed under the Oaths Act to take statutory declarations. The witness must be sure that both you and the person you are appointing as your Medical Agent signed the document in his or her presence and that all of you appeared to understand what you were doing when completing the document. By law neither your treating doctor nor any of your Medical Agents can witness your MPA form.

If you choose not to appoint a MPA and you become unable to legally make or communicate decisions for yourself, any medical decisions that need to be made can be made by family members. The Guardianship and Administration Act allows informal arrangements whereby families are authorised to make medical and lifestyle decisions on an incompetent person's behalf where there are no formal arrangements (such as an advance directive or a Guardianship Order) in place.

2. Anticipatory Direction

This is a legal document that enables you to record your wishes about what medical care and treatment you want, or don't want, should decisions need to be made about these things towards the end of your life when you are no longer able to communicate those wishes. Anticipatory Directions cannot be used as a means of requesting euthanasia.

You can only make an Anticipatory Direction if you are at least 18 years of age and competent to make decisions about your own affairs by yourself. An Anticipatory Direction only takes effect when you are in the final stages of a terminal illness, and you are no longer competent to make your own decisions. Witnessing requirements are the same as for the MPA.

3. An Enduring Power of Guardianship

This is a legal document that enables you to appoint another person to make personal life style decisions, such as where you would live, when through disability you are unable to make those decisions for yourself. An Enduring Guardian can also make medical decisions for you when you are no longer able to make your own, unless you have appointed a separate Medical Agent, in which case the Medical Agent makes medical decisions.

For the purposes of the Respecting Patient Choices Program we encourage any person wanting to appoint an Enduring Guardian do so with the assistance of a social worker. If an Enduring Guardian is already appointed this should be documented and filed as for other legal documents.

4. The Statement of Choices

You may choose to record your wishes regarding future medical treatments on the *Statement of Choices* form. It is still most important to discuss your wishes with your Medical Agent or Enduring Guardian (if appointed), family and doctor. You should note that the Statement of Choices is designed to inform your Medical Agent and the doctors of your medical treatment wishes. It is not legally binding, unlike an Anticipatory Direction. If you become unable to make decisions this information will assist them in making decisions that are in your best interests.

How do I change or revoke my Advance Care Plan?

There are a number of reasons why you might want to change or revoke your MPA, your Anticipatory Direction or your Statement of Choices. Maybe your relationship with your Medical Agent has changed, or the person you appointed is no longer appropriate for the role. Your medical circumstances or wishes may have changed. You can change or revoke these documents, whilst you are still legally competent, verbally or in writing or by destroying them, or requesting that they be destroyed. You can also revoke these documents by completing a new document (e.g. appointing a new Medical Agent or recording new choices). The most recent dated document overrides the older document. It is also important to inform all your Medical Agents of the changes and provide them with new documents.

After completing the Advance Care Plan the original remains with you and copies should be given to:

- all your Medical Agents and/or your Enduring Guardian
- your local doctor (GP)
 - the medical records department at the organisation where you have completed the documents
- other hospitals/clinics you normally attend (with a covering explanatory letter)
- SA Ambulance Service
- Medic Alert Register

You may also wish to share extra copies with others (eg. next of kin, local religious leader and your solicitor).

Need further information?

If you need assistance in completing this document or would like more information please contact a Respecting Patient Choices Consultant:

Name

Telephone



South Australian Advance Care Plan Contact Information

Name: _____ (or identity label)

Address: _____

Date of Birth: _____ Telephone: _____

Name of first Medical Agent*:

Tel no: _____

Mobile: _____

Work: _____

Relationship: _____

Date: _____

**or enduring Guardian if appointed*

****Name of second Medical Agent:**

Tel No: _____

Mobile: _____

Work: _____

Relationship: _____

Date: _____

***If you choose to have more than one Medical Agent*

Your Advance Care Plan includes the following documents:

Medical Power of Attorney	Yes / No
Anticipatory Direction	Yes / No
Enduring Power of Guardianship	Yes / No
Statement of Choices	Yes / No

Copies of your Advance Care Plan have been given to:
(Complete as many lines as applicable)

- 1 _____ General Practitioner _____
- 2 _____ Hospital _____
- 3 _____ Nursing Home _____
- 4 _____ SA Ambulance
- 5 _____ Spiritual Leader
- 6 _____ Medic Alert
- 7 _____ Solicitor

Medical Power of Attorney

Part 1 – Appointment of Medical Agent

1. I,.....
.....
.....

.....
[Insert full name, address and occupation]

appoint the following person(s) to be my medical agent(s):

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

.....
[Insert full name, address and occupation of the agent. If two or more agents are appointed, the order of appointment must be indicated by placing the numbers 1, 2, 3... beside each name. This indicates that, if the first is not available, the second is to be consulted, if the first and second are not available, the third is to be consulted and so on. It should be noted that a medical power of attorney cannot provide for the joint exercise of the power. (See section 8(6) of the Consent to Medical Treatment and Palliative Care Act 1995.)]

2. I authorise my medical agent to make decisions about my medical treatment if I should become unable to do so for myself.

3. I require my medical agent to observe the following conditions and directions in exercising, or in relation to the exercise of, the powers conferred by this medical power of attorney:

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

.....
[Here set out any conditions to which the power is subject and any directions to the agent.]

4. This an enduring power of attorney made under the: *Consent to Medical Treatment and Palliative Care Act 1995*

..... Dated the day of 20..
[Signature of person appointing the agent]

Part 2 – Witness's certificate

I,
.....
.....

[Insert full name and address of the witness and the qualification by virtue of which the witness is an *authorised witness under the Consent to Medical Treatment and Palliative Care Act 1995]

certify that –

- (a) the grantor of this medical power of attorney signed it freely and voluntarily in my presence; and
- (b) appeared to understand the effect of the power.

..... Dated the day of 20..
[Signature of witness]

Note-* **Authorised witness** means a justice of the peace, a commissioner for taking affidavits in the Supreme Court, a member of the clergy, a registered pharmacist, or a manager of an authorised deposit-taking institution or police officer appointed under the *Oaths Act 1936* to take statutory declarations.

Medical Power of Attorney

Part 3 - Acceptance of Power of Attorney 1

I,.....
.....
.....
.....

[Insert full name, address and occupation]

accept appointment as a medical agent under this medical power of attorney and undertake to exercise the powers conferred honestly, in accordance with the conditions and directions set out above, and, subject to that, in what I genuinely believe to be my principal's best interests.

.....
[Signature of the medical agent]

Acceptance of Power of Attorney 2 (If more than one Medical Agent appointed)

I,.....
.....
.....
.....

[insert full name, address and occupation]

accept appointment as a medical agent under this medical power of attorney and undertake to exercise the powers conferred honestly, in accordance with the conditions and directions set out above, and, subject to that, in what I genuinely believe to be my principal's best interests.

.....
[Signature of medical agent 2]

Acceptance of Power of Attorney 3 (If more than one Medical Agent appointed)

I,.....
.....
.....
.....

[Insert full name, address and occupation]

accept appointment as a medical agent under this medical power of attorney and undertake to exercise the powers conferred honestly, in accordance with the conditions and directions set out above, and, subject to that, in what I genuinely believe to be my principal's best interests.

.....
[Signature of medical agent 3]

Part 4 - Witness's certificate 1

I,.....
.....
.....

[Insert full name and address of the witness and the qualification by virtue of which the witness is an authorised witness under the Consent to Medical Treatment and Palliative Care Act 1995],*
certify that –

- (a) the grantee of this medical power of attorney signed it freely and voluntarily in my presence; and
- (b) appeared to understand the effect of the power.

.....
[Signature of witness]

Dated the day of 20

Witness's certificate 2

I,.....
.....
.....

[Insert full name and address of the witness and the qualification by virtue of which the witness is an authorised witness under the Consent to Medical Treatment and Palliative Care Act 1995]*
certify that –

- (a) the grantee of this medical power of attorney signed it freely and voluntarily in my presence; and
- (b) appeared to understand the effect of the power.

.....
[Signature of witness]

Dated the day of 20

Witness's certificate 3

I,.....
.....
.....

[Insert full name and address of the witness and the qualification by virtue of which the witness is an authorised witness under the Consent to Medical Treatment and Palliative Care Act 1995],*
certify that –

- (a) the grantee of this medical power of attorney signed it freely and voluntarily in my presence; and
- (b) appeared to understand the effect of the power.

.....
[Signature of witness]

Dated the day of 20

Anticipatory Direction

Part 1 – Anticipatory Direction

1.I.....
.....
.....
.....

[Insert full name, address and occupation]

direct that if, at some future time, I am –

- (a) in the terminal phase of a terminal illness, or in a persistent vegetative state; and
- (b) incapable of making decisions about my own medical treatment,

effect is to be given to the following expression of my wishes:

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

[The person by whom the direction is given must include here a statement of his or her wishes. The statement should clearly set out the kinds of medical treatment that the person wants, or the kinds of medical treatment that the person does not want, or both. If the consent, or refusal of consent, is to operate only in certain circumstances, or on certain conditions, the statement should define those circumstances or conditions.]

2. This direction is given under the *Consent to Medical Treatment and Palliative Care Act 1995*.

.....
[Signature of person giving the direction]

Dated the day of 2005

Part 2 – Witness's certificate

I,.....
.....
.....
.....

[Insert full name and address of the witness and the qualification by virtue of which the witness is an *authorised witness under the *Consent to Medical Treatment and Palliative Care Act 1995*]

certify that the person whose signature appears above:

- (a) signed this direction in my presence; and
- (b) appeared to understand the nature and effect of the direction.

.....
[Signature of witness]

Dated the day of 20

Note –* **Authorised witness** means a justice of the peace, a commissioner for taking affidavits in the Supreme Court, a member of the clergy, a registered pharmacist, or a manager of an authorised deposit-taking institution or policy officer appointed under the *Oaths Act 1936* to take statutory declarations.

Affix identification label if available

South Australian Statement of Choices - Form 1

This Statement of Choices, based on your values and beliefs, will be used to guide future medical decisions, if you lose the ability to communicate your wishes. You can also complete legal documents such as an Anticipatory Direction, Medical Power of Attorney or an Enduring Power of Guardianship (*see below). If you have completed legal documents, your statement of choices should be consistent with them.

I _____ (person's name)

of _____ (person's address)

I request that my stated choices recorded below be respected by my family, my Medical Agent(s) (if appointed) and my doctors. I understand that it is important to discuss my values, beliefs and wishes with them.

Choices for Treatment and Care.

Initial the choices you want and place a line through the choices you do not want. You may write specific requests on the lines provided.

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

You may write specific requests here:

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 wish to be allowed to die naturally and with dignity. I do not want extraordinary or burdensome treatments, which may be used to prolong my life. If any of these specific treatments ******(documented below) or similarly invasive 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.

**** You may write here specific treatments that you want or don't want, such as Cardio-Pulmonary Resuscitation, respirator/ventilator, tube feeding, renal dialysis, intravenous fluids, antibiotics.**

OR

If you do not wish to make a plan for your treatment and care, please initial the box below.

3. I understand that if I do not initial either of the above boxes, that decisions regarding life-prolonging treatments will be made by my Medical Agent (if appointed) or other person responsible for making my medical decisions, in consultation with my treating Doctors.

You may write specific requests here:

*If you have appointed an Enduring Guardian, but not a Medical Agent your Enduring Guardian can make medical decisions for you.

Other requests for my medical care:

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

Other points which are important to me:

If you have other end of life wishes, e.g. organ or body donation, you may wish to attach your documentation to this plan. NB. If you wish to be an organ donor, it is important to register on the Australian Organ Donor register and discuss your wishes with your next-of-kin/family.

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

If I am nearing the end of my life, I want the following (list things which would be important to you):

If I am nearing the end of my life and cannot speak, please give my family and friends 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. I am of sound mind, and I have read and I understand the importance of this document and have had this document explained to me to my satisfaction.

Signature _____
(Your signature)

Date _____

Witness signature _____
(Preferably medical agent's/enduring guardians signature)

Date _____

Witness name _____

Relationship _____