End-of-Life Choice
Society of New Zealand Inc

Advance Directive for health care

Full name: ……

Address: ……

DOB: ……

It is my express wish that SHOULD I DEVELOP ANY OF THE FOLLOWING CONDITIONS:

a) senility, or severe degenerative brain disease (due to Alzheimer's disease, arterial disease, AIDS, or other agency); or

b) serious brain damage resulting from accidental or other injury or illness; or

c) advanced or terminal malignant disease; or

d) severely incapacitating and progressive degenerative disease of the nerves or muscles;

AND as a result, BECOME MENTALLY OR PHYSICALLY INCOMPETENT TO EXPRESS MY WISHES about accepting or declining life sustaining treatment, then I request that:

(NOTE: Tick the desired option and draw a line through the unwanted option)

In the event of a cardiac arrest, regardless of the cause

❏ I want cardiopulmonary resuscitation
❏ I do not want cardiopulmonary resuscitation

In the event that I cannot breathe for myself, regardless of the cause

❏ I wish to be placed on a respirator or other means of life support
❏ I do not wish to be placed on a respirator or other means of life support

In the event of any separate illness that may threaten my life

❏ I want appropriate treatment
❏ I do not want treatment for any separate illness – for example, pneumonia, a heart or kidney condition

If I become unable to swallow food, fluid, or medication

❑ I wish to receive these by artificial means
❑ I do not wish to receive these by artificial means. However, in this situation, I request immediate and maximum care for the relief of physical or mental suffering associated with refusal of food, fluid or medication, such as good comfort care, mouth care, attention to skin and pressure areas, bladder and bowel care, analgesia and sedation.

If my behavior becomes violent, noisy, or in other ways degrading, or if I appear to be suffering pain, those symptoms

❑ Should be controlled with suitable drugs, regardless of the consequences to my physical health or my survival.

If I have severe dementia and am totally physically dependent e.g. consistently unable to recognise family and friends and needing assistance with toileting and dressing, unable to feed myself, then (tick only one)

❑ I wish to receive nutrition by assisted spoon feeding
❑ I accept spoon feeding, but only if my acceptance appears to my treating doctor to be voluntary and only if it appears that I am enjoying my food
❑ I do not wish to receive nutrition by assisted spoon feeding even if it appears that I do so voluntarily and with enjoyment. However, in this situation, I request immediate and maximum care for the physical or mental suffering associated with refusal of spoon feeding, such as good comfort care, mouth care, attention to skin and pressure areas, bladder and bowel care, analgesia and sedation.

I understand that terminal sedation is different from assisted dying. Under terminal sedation, the goal is to keep me comfortable and peaceful during the dying process, to neither hasten nor prolong my dying. If I am offered terminal sedation by my attending medical practitioner, then

❑ I wish to accept this
❑ I wish to reject this but nevertheless I wish to receive maximum relief for pain, distress or suffering, even if that may have the consequence of shortening my life.

Relief of pain, distress or suffering

❑ I wish to receive maximum relief for pain, distress or suffering, even if that may have the consequence of shortening my life.

Other Wishes:
(If you wish, you can write your own additional instructions here or attach them separately).

Important Notes for my treating doctor:
(Here you can document anything your hospital doctor should know about your medical history. This could be an underlying condition such as epilepsy, or any allergic reactions you may have to certain medications that you know about at the time of writing this Advance Directive. Or attach your notes separately.)

The objective of this *Advance Directive* is to minimise distress or indignity which I may suffer during an incurable illness, and to spare my medical advisers or relatives, or both, the burden of making difficult decisions on my behalf.

Signed by me, ... Date .....

My full name .....

Witness

(It is preferable that the witness be your doctor or lawyer. This is necessary where there may be some doubt as to competency.)

Statement by witness: I, ..., hereby declare that in my opinion the above person ..... is of sound mind and understands the meaning and implications of this *Advance Directive*.

Signed .....Date .....

Full name .....

Agent

(It is necessary that the Agent be a person who knows you well and understands you. You need to be able to trust your Agent to make decisions on your behalf.)

I have asked the following person to ensure that my wishes expressed in this Advance Directive are complied with to the fullest extent possible.

Full name of Agent: .....

Agent's contact details e.g. phone, email : ....

Agent's home address: .....

Agent's Signature: .....

Review

Reviewed and confirmed by me (full name) .....

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

Witness name: .....

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

Reviewed and confirmed by me (full name) .....

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

Witness name: .....

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

Reviewed and confirmed by me (full name) .....

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

Witness name: .....

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

Reviewed and confirmed by me (full name) .....

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

Witness name: .....

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