Advance Directive Form

1. I, (full names) _____,

   (ID No. _____) being of sound mind, willfully and voluntarily make known my desires as set out hereunder and confirm that I am under no constraint or undue influence. _____ *(initial)*

2. I revoke any previous Advance Directive or Living Will I may have made. _____ *(initial)*

3. If the time comes when I lack the capacity to give directions for my health care, this statement shall stand as an expression of my wishes and directions. _____ *(initial)*

4. If I am unable to make decisions only because I am being kept sedated, I would like the sedation lifted so I can rationally consider my situation and decide for myself to accept or refuse a particular therapy. _____ *(initial)*

5. I designate, as my Primary Medical Proxy:

Name and surname		
ID Number		
Residential address		
Contact details	Tel # day:	Tel # night:
	Mobile #:	Email:

6. If the above named Primary Medical Proxy should be or become at any time unable or unwilling to act on my behalf, I designate, as my Alternative Medical Proxy:

Name and surname		
ID Number		
Residential address		
Contact details	Tel # day:	Tel # night:
	Mobile #:	Email:

7A. PLEASE COMPLETE SECTION 7 BY SELECTING AND INITIALLING NEXT TO THE SENTENCE THAT BEST DESCRIBES YOUR DIRECTIONS, IN EACH OF THE FOLLOWING SCENARIOS. CHOOSE EITHER (i) *OR* (ii).

a) A sudden onset of a <u>life-threatening</u> illness of an <u>irreversible</u> nature, for example brain injury, stroke, etc.:

(i) I wish to receive only such care that will keep me comfortable and pain free.

Initial:

OR

(ii) I request all treatment(s) available and accept that this may prolong my dying.

Initial:

b) A long standing <u>terminal</u> illness with <u>no cure</u>, for example organ failure, incurable cancer, etc.:

(i) I wish to receive only treatment(s) and care that will keep me comfortable and pain free.

Initial:

OR

(ii) I request all available treatment and accept that continuation of this may prolong my dying.

Initial:

c) Advanced medical incapacity and physical decline, with no cure, for example advanced Alzheimer's Dementia:

(i) I wish to receive only treatment(s) and care that will keep me comfortable and pain free.

Initial:

OR

(ii) I request all treatment(s) available and accept that this may prolong my dying.

Initial:

d) _____

Insert any other condition applicable to you

(i) I wish to receive only treatment(s) and care that will keep me comfortable and pain free.

Initial:

OR

(ii) I request all treatment(s) available and accept that this may prolong my dying.

Initial:

e) _____

Insert any other condition applicable to you

(i) I wish to receive only treatment(s) and care that will keep me comfortable and pain free.

Initial:

OR

(ii) I request all treatment(s) available and accept that this may prolong my dying.

Initial:

7b. THE FOLLOWING STATEMENTS APPLY TO THE CIRCUMSTANCES DESCRIBED IN SECTION 7a ABOVE AND WHEN SPECIFIC ARTIFICIAL SUPPORT MEASURES AND TREATMENTS ARE OFFERED. REMEMBER THAT THESE MEASURES MAY PROLONG LIFE BUT WILL NOT REVERSE OR CURE THE UNDERLYING CONDITION.

PLEASE COMPLETE SECTION 7B BY SELECTING AND INITIALING NEXT TO THE SENTENCE THAT BEST DESCRIBES YOUR DIRECTIONS, IN EACH OF THE FOLLOWING SCENARIOS. <u>CHOOSE EITHER (i) OR (ii) OR (iii)</u>

a) Electrical, mechanical or other artificial stimulation of my heart, for example defibrillation and CRP:

(i) I request electrical, mechanical or other artificial stimulation of my heart.

Initial:

OR

(ii) I refuse electrical, mechanical or other artificial stimulation of my heart.

Initial:

b) Artificial support with breathing, for example by ventilatory support:

(i) I request the use of a respirator or ventilator.

Initial:

OR

(ii) I refuse the use of a respirator or ventilator.

Initial:

c) Artificial feeding if able to swallow but require manual force feeding, for example by a care giver to maintain nutrition:

(i) I request to be fed should I no longer be able to feed myself.

Initial:

OR

(ii) I refuse to be fed should I no longer be able to feed myself.

Initial:

d) Artificial feeding if I am unable to swallow e.g. PEG tube, NB tube, or central intravenous line:

(i) I request artificial feeding.

Initial:

OR

(ii) I refuse artificial feeding.

Initial:

e) Artificial hydration by intravenous line:

(i) I request artificial hydration by intravenous line.

Initial:

OR

(ii) I refuse artificial hydration by intravenous line.

Initial:

f) Antibiotics necessary to treat infection:

(i) I request antibiotics if this may assist with controlling my symptoms and comfort only.

Initial:

OR

(ii) I request antibiotics of any nature or method of administration including intravenous antibiotics in hospital to treat an infection.

Initial:

OR

(iii) I refuse antibiotics of any nature or method of administration completely.

Initial:

g) Transfer to an intensive or high care unit where artificial support measures are used:

(i) I request to be transferred to an intensive or high care unit.

Initial:

OR

(ii) I refuse to be transferred to an intensive or high care unit.

Initial:

[Insert any other requests/refusals that may be applicable to you]

h) _____

_____ Initial:

i) _____

_____ Initial:

j) _____

_____ Initial:

8. PLEASE SELECT <u>ONLY</u> OPTION (a) <u>OR</u> OPTION (b)

a) I give my designated Proxy(s) the authority to make medical decisions on my behalf according to the information provided by me in Section 7 hereof.

Initial:

OR

b) I have not designated a Proxy but wish the health care providers to make decisions according to the information provided by me in Section 7 hereof.

Initial:

9. PLEASE SELECT AND INITIAL NEXT TO THE SENTENCE THAT BEST DESCRIBES YOUR DIRECTIONS:

a) I wish for my heath care provider to discuss this Advance Directive with my Medical Proxy as per Section 5 and 6.

Initial:

b) If my health care provider will not follow this Advance Directive, I ask that my care be transferred to another health care provider who will respect my legal and human rights.

Initial:

c) If I should be a patient in a hospital, or resident in a health care or long term care facility which will not follow this Advance Directive, I ask that I be transferred to another hospital or care facility.

Initial:

d) I would accept being in a nursing home if I needed constant or permanent care.

Initial:

e) If I needed constant or permanent care, I would want to be cared for at home and have home-based care.

Initial:

f) I am an Organ Donor, registered with the Organ Donor Foundation

Initial:

g) I do not want a blood transfusion under any circumstances.

Initial:

h) If I am dying, I would prefer to spend my last days at home.

Initial:

i) If I am dying, I would prefer to spend my last days in hospital.

Initial:

j) Additional instructions [Please list any further cultural, religious or personal wishes].

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Initial:

Note that there are 3 separate opportunities to sign on the pages that follow. Refer to the "Changing your mind" section (Page 16) in the Advance Directive Planning Guide and remember that your new signature and date has to be witnessed regardless if you are making changes to the terms of your directive or not.

FIRST AND ORIGINAL SIGNING

Signed by me, (print full names) _____ in

the presence of my witnesses at _____, South Africa

Signature: _____ 1st Signing Date: _____

1st WITNESS:

Print name _____

ID Number: _____

Full address _____

_____

I DECLARE THAT the compiler and further witnesses signed this document in my presence on the aforementioned date. I further declare that:

I am over the age of 18,
I am not a person named as a Medical Proxy in this document,
I am not married to the compiler,
I am not a spouse of any of the Medical Proxies mentioned above, and
I hold no other interests in the execution of this document.

Signature of witness _____ Date: _____

2nd WITNESS:

Print name _____

ID Number: _____

Full address _____

_____

I DECLARE THAT the compiler and further witnesses signed this document in my presence on the aforementioned date. I further declare that:

I am over the age of 18,
I am not a person named as a Medical Proxy in this document,
I am not married to the compiler,
I am not a spouse of any of the Medical Proxies mentioned above, and
I hold no other interests in the execution of this document.

Signature of witness _____ Date: _____

SECOND SIGNING

Signed by me, (print full names) _____ in

the presence of my witnesses at _____, South Africa

Signature: _____ 2nd Signing Date: _____

1st WITNESS:

Print name _____

ID Number: _____

Full address _____

_____

I DECLARE THAT the compiler and further witnesses signed this document in my presence on the aforementioned date. I further declare that:

I am over the age of 18,
I am not a person named as a Medical Proxy in this document,
I am not married to the compiler,
I am not a spouse of any of the Medical Proxies mentioned above, and
I hold no other interests in the execution of this document.

Signature of witness _____ Date: _____

2nd WITNESS:

Print name _____

ID Number: _____

Full address _____

_____

I DECLARE THAT the compiler and further witnesses signed this document in my presence on the aforementioned date. I further declare that:

I am over the age of 18,
I am not a person named as a Medical Proxy in this document,
I am not married to the compiler,
I am not a spouse of any of the Medical Proxies mentioned above, and
I hold no other interests in the execution of this document.

Signature of witness _____ Date: _____

THIRD SIGNING

Signed by me, (print full names) _____ in

the presence of my witnesses at _____, South Africa

Signature: _____ 3rd Signing Date: _____

1st WITNESS:

Print name _____

ID Number: _____

Full address _____

_____

I DECLARE THAT the compiler and further witnesses signed this document in my presence on the aforementioned date. I further declare that:

I am over the age of 18,
I am not a person named as a Medical Proxy in this document,
I am not married to the compiler,
I am not a spouse of any of the Medical Proxies mentioned above, and
I hold no other interests in the execution of this document.

Signature of witness _____ Date: _____

2nd WITNESS:

Print name _____

ID Number: _____

Full address _____

_____

I DECLARE THAT the compiler and further witnesses signed this document in my presence on the aforementioned date. I further declare that:

I am over the age of 18,
I am not a person named as a Medical Proxy in this document,
I am not married to the compiler,
I am not a spouse of any of the Medical Proxies mentioned above, and
I hold no other interests in the execution of this document.

Signature of witness _____ Date: _____

Wallet-sized Advance Directive Notification Card

This card lets healthcare workers know you have talked to your family about Advance Directives and provides them with contact names and numbers.

It is essential that your health care provider be made aware that you have executed an Advance Directive. Your treating physicians should be given a copy of the documents. The wallet card is one way to do this. Fill out the card, then cut it out and carry it with you at all times.

To fold the card to fit in your wallet, fold on the dotted line with the words facing out.

ADVANCE DIRECTIVE	**I HAVE AN ADVANCE DIRECTIVE/**	**OTHER COPIES ARE HELD BY:**
	My name:	Name:
	My ID#:	Phone #:
	My Doctor's name:	Name:
	Doctor's Phone #:	Phone #:
	MY PRIMARY HEALTH CARE PROXY:	**MY ALTERNATIVE HEALTH CARE PROXY:**
	Proxy's Name:	Proxy's Name:
	Phone #:	Phone #: