Form 4

Powers of Attorney Act 1998 **(Qld) section 44(2)**
Version 5: approved for use from 30 November 2020.

For patient record purposes, health services can affix identification label here

Advance health directive

(Queensland)

Use this form to give directions about your future health care and special health care. You can also use this form to appoint an attorney(s) for health matters.

To help you complete this form, please read Form 10 — Advance health directive explanatory guide first.

You should then talk to people who are important to you and can help inform your healthcare choices including your doctor, family and friends.

Forms and explanatory guides are available at www.qld.gov.au/guardianship-planahead

What is an advance health directive?

At some point in the future, you may be unable to make decisions about your health care, even temporarily.

Your advance health directive is a legal document that allows you to give directions about your future health care and special health care**.**

» Health care **includes most medical treatments, procedures and services to treat both physical and mental conditions. When nearing the end of your life, the definition of health care also includes** life-sustaining treatment**.**

» Special health care **includes special procedures such as participation in special medical research.**

Your advance health directive also allows your wishes to be known and gives health professionals direction about the treatment you want.

As the person who is making this advance health directive, you are referred to as the 'principal'**. Any directions you give in this advance health directive will only** operate if you do not have capacity **to make decisions about your health care.**

Appointing an attorney (decision-maker)

You can also use this form to appoint someone that you trust to make decisions about your health care if there is a time when you do not have capacity to make decisions about your health care**. The person you appoint is called your** 'attorney'**.**

Important information about your advance health directive

» **This form can only be completed by an adult who has capacity to make an advance health directive. This means you must understand the nature and effect of the document you are signing. You must be making this document freely and voluntarily, not due to pressure from someone else to make it.**

» **A doctor must sign section 5 'Doctor certificate' of this form.**

» You must sign this form in the presence of an eligible witness **(a justice of the peace (JP), commissioner for declarations, lawyer or notary public).**

» **If an interpreter is required to interpret or translate this document, they should complete Form 7 — Interpreter's/ translator's statement.**

» **You are not required to register this advance health directive anywhere.**

What to do with this advance health directive once complete:

» **give a certified copy to your attorney(s) (if appointed), lawyer, doctor or health provider(s)**

» **notify your close family and friends that you have made an advance health directive and where to find the document.**

SECTION 1: YOUR PERSONAL DETAILS

You must fill in your full name, date of birth and address.

Refer to section 1, page 5 of Form 10 — Advance health directive explanatory guide.

Full name	Janet Elizabeth Byrnes		
Date of birth	19/5/1978		
Address	6 City Street		
	ROCKHAMPTON **Suburb**	QLD **State**	4555 **Postcode**
Phone number	07 4279 2222		
Email	janetb@email.com.au		

SECTION 2: YOUR HEALTH CONDITIONS AND CONCERNS

Refer to section 2, page 5 of Form 10 — Advance health directive explanatory guide.

Cross out this section if you do not want to complete it. If you do complete this section cross out any space in the box that you do not use.

My major health conditions and concerns are:

JEB & JP\CD
to initial

SECTION 3: YOUR VIEWS, WISHES AND PREFERENCES

This section lets your health provider, family and friends know what is important to you now and into the future.

You are not giving directions about your health care **(section 4 allows you to do this). You should discuss this section with your doctor before completing it.**

Refer to section 3, pages 5–6 of Form 10 — Advance health directive explanatory guide.

Cross out this section if you do not want to complete it. If you do complete this section cross out any space in the boxes that you do not use.

(a) These things are important to me: (*Describe what living well means to you now and into the future* **e.g. spending time with your family and friends, living in your own home)**

Because of my religious beliefs, I do not wish to receive any blood transfusions or organ transplants or tissues

JEB & JP\CD
to initial

(b) These things worry me about my future: **(e.g. being unable to live at home, being unable to communicate)**

(c) **These are the cultural, religious or spiritual values, rituals or beliefs I would like considered in my health care:**

(d) **When I am nearing death, the following would be important to me and would comfort me: (e.g. you may prefer to die at home or you may like a certain type of music played)**

(e) **I would prefer these people to be involved in discussions about my health care:**

(f) **I would prefer these people not be involved in discussions about my health care:**

JEB & JP\CD
to initial

SECTION 4: YOUR DIRECTIONS

Before completing section 4, it is recommended that you discuss your proposed directions with your doctor.

DIRECTIONS ABOUT LIFE-SUSTAINING TREATMENT

This part allows you to give directions about life-sustaining treatment when you are nearing the end of your life. **For directions about health care other than life-sustaining treatments, complete the part 'Directions about other health care' on page 7.**

Life-sustaining treatments are aimed at sustaining or prolonging your life (i.e. keeping you alive or delaying your death). **Examples could include CPR (cardiopulmonary resuscitation) and assisted ventilation (e.g. the use of a breathing machine).**

Your directions about life-sustaining treatment that you provide below will only apply if you are unlikely to regain capacity to make your own decisions about health care and one of the following applies:

- **you are so unwell due to a terminal illness or condition that, in the opinion of two doctors, you are reasonably likely to die in the next 12 months**
- **you are so unwell due to an injury or illness that there is no reasonable prospect that you will recover to the extent that you can live without life-sustaining treatment**
- **you are permanently unconscious (with no reasonable prospect of regaining consciousness)**
- **you are in a persistent vegetative state (involving severe and irreversible brain damage).**

A health provider does not have to follow directions in an advance health directive that are not consistent with good medical practice or will not benefit you. A health provider also does not have to follow directions that are uncertain or where circumstances, including advances in medicine, have changed to the point that your directions are no longer appropriate. Before completing this section, it is recommended that you discuss your proposed directions with your doctor.

You can only choose one option.

Read all four options (see next page for option 4) before you make a decision.

Refer to section 4, pages 7–8 of Form 10 — Advance health directive explanatory guide.

I give the following directions about life-sustaining treatment:

*(Please choose **only one** of the following four options)*

Option 1

☐ I consent to all **treatments aimed at sustaining or prolonging my life.**

OR

Option 2

☐ I refuse **any treatments aimed at sustaining or prolonging my life.**

OR

Option 3

☐ I cannot decide at this point. **I want my attorney(s) to make the decisions about life-sustaining treatment on my behalf at the time the decision needs to be made using the information in this advance health directive and in consultation with my health providers and the people I have listed in section 3.**

OR

See next page for option 4.

Option 4

☑ **I give the following specific directions about life-sustaining treatments:**

(Tick one box per row in the table below)

Life-sustaining treatment	(a) I consent to this treatment in all circumstances	(b) I refuse this treatment in all circumstances	(c) I consent to this treatment in the following circumstances *(You must specify the particular circumstances for each treatment)*
CPR (cardiopulmonary resuscitation) *(For option (c), specify circumstances here)*	☐	☑	☐
Assisted ventilation (e.g. a machine which assists your breathing through a face mask or a breathing tube) *(For option (c), specify circumstances here)*	☐	☑	☐
Artificial nutrition (e.g. a feeding tube through the nose or stomach) *(For option (c), specify circumstances here)*	☐	☑	☐
Artificial hydration (e.g. intravenous (IV) fluids) *(For option (c), specify circumstances here)*	☐	☑	☐
Antibiotics *(For option (c), specify circumstances here)*	☐	☑	☐
Other life-sustaining treatment (*state the treatment*, e.g. kidney dialysis) *(For option (c), specify circumstances here)*	☐	☐	☑ I only want treatment when necessary to maintain my comfort and dignity with particular emphasis on the relief of pain. Only if required for my dignity and comfort as part of my palliative care no surgical operation is to be performed.

☐ **I need more space.**

Attach any additional pages to this form and tick the box to indicate that extra pages are attached.

DIRECTIONS ABOUT OTHER HEALTH CARE

This part allows you to give directions about health care, other than life-sustaining treatment.

You can use this part to give directions to consent to or refuse health care.

You do not need to specify a health condition but your directions need to be clear.

Refer to section 4, page 9 of Form 10 — Advance health directive explanatory guide.

I give the following directions about my health care:

Health condition (if relevant)	Directions about my health care
	JEB & JP\CD to initial

☐ **I need more space.**

Attach any additional pages to this form and tick the box to indicate that extra pages are attached.

DIRECTIONS ABOUT BLOOD TRANSFUSIONS

A blood transfusion is the transfer of blood, including blood products (e.g. red cells, platelets and plasma) from one person to another.

Refer to section 4, page 9 of Form 10 — Advance health directive explanatory guide.

I give the following direction about blood transfusions:

(Tick one box only)

☐ **I consent to a blood transfusion**

OR

☑ **I do not consent to a blood transfusion**

OR

☐ **other:**

(*If you tick this box you must specify the circumstances or types of transfusions that you consent to or refuse,* **e.g. I consent to a transfusion of blood products but not blood.)**

SECTION 5: DOCTOR CERTIFICATE

A doctor must complete, sign and date this section.

INFORMATION FOR THE DOCTOR

Refer to section 5, pages 9–10 of Form 10 — Advance health directive explanatory guide and the *Queensland Capacity Assessment Guidelines 2020*.

By signing below, I certify that:

- **I am a doctor.**
- **I have discussed the contents of this advance health directive with the principal.**
- **At the time of making this advance health directive the principal appeared to me to have the capacity to make this advance health directive. The principal appeared to:**
  - **understand the nature and effect of this advance health directive**
  - **be capable of making this advance health directive freely and voluntarily.**
- **I am not:**
  - **the person witnessing this advance health directive**
  - **the person signing this advance health directive for the principal**
  - **an attorney of the principal**
  - **a relation of the principal or relation of an attorney of the principal**
  - **a beneficiary under the principal's will.**

Doctor's name	Dr Andrew Postle		
Name of facility or practice	16 Main Street		
Address of facility or practice			
	ROCKHAMPTON **Suburb**	QLD **State**	4555 **Postcode**
Phone number	07 4927 222		
Doctor's signature: Dr Andrew Postle **Date:** Date			

SECTION 6: APPOINTING AN ATTORNEY(S) FOR HEALTH MATTERS

This section allows you to appoint one or more attorneys to make decisions about health care for you. You can choose how your attorney(s) can make decisions (e.g. jointly, severally, by a majority, successively or alternatively). You can also set terms on your attorney(s)' decision-making power or provide instructions on how your attorney(s) exercise their power.

WHO ARE YOU APPOINTING AS YOUR ATTORNEY(S) FOR HEALTH MATTERS?

Your attorney(s) must:

- **have capacity to make decisions for the matter they are being appointed for**
- **be 18 years or older**
- **not be a service provider for a residential service if you are a resident there**
- **not be your paid carer in the previous three years or your health provider.**

Note: a paid carer is someone who is paid a fee or wage to care for a person but not someone receiving a carer's pension or benefit.

Your attorney(s) cannot make decisions that are inconsistent with your directions in section 4 if those directions are clear and can be followed by your health providers.

Refer to section 6, pages 10–11 of Form 10 — Advance health directive explanatory guide.

Cross out this part if you do not want to complete it.

If you do not want to appoint an attorney(s) for health matters, or you have already appointed one in an enduring power of attorney and you do not want to change it, go to section 7.

I appoint the person(s) listed below as my attorney(s) for health matters: (in no particular order)

Full name	Mrs Judith Mavis Ringbold		
Address	22 East Street		
	ROCKHAMPTON **Suburb**	QLD **State**	4555 **Postcode**
Phone number			
Email			

Full name			
Address			
	Suburb	**State**	**Postcode**
Phone number			
Email			

Full name			
Address			
	Suburb	**State**	**Postcode**
Phone number			
Email			

Full name	**JEB & JP\CD to initial**		
Address			
	Suburb	**State**	**Postcode**
Phone number			
Email			

I am appointing an additional attorney(s) and need more space.

Attach any additional pages to this form and tick the box to indicate that extra pages are attached.

HOW MUST YOUR ATTORNEYS MAKE DECISIONS?

Only complete this part if you are appointing more than one attorney.

Refer to section 6, pages 12–13 of Form 10 — Advance health directive explanatory guide.

If you do not complete this part your attorneys must make decisions jointly.

I authorise my attorneys to make decisions:
(Tick one box only)

☐ **jointly (all of my attorneys must agree on all decisions)**

OR

☑ **severally (any one of my attorneys may decide)**

OR

☐ **by a majority (more than half of my attorneys must agree on all decisions)**

OR

☐ **other: (e.g. jointly and severally, or appointing a successive or alternative attorney)**
(*If you choose 'other', please specify how you want your attorneys to make decisions***)**

TERMS AND INSTRUCTIONS FOR YOUR ATTORNEY(S)

Only complete this part if you want to set terms on the exercise of power by your attorney(s) or provide instructions to your attorney(s) about the exercise of their powers.

Refer to section 6, page 13 of Form 10 — Advance health directive explanatory guide.

Cross out this part if you do not want to complete it. If you do complete this part cross out any space in the box that you do not use.

Write the terms and instructions for your attorney(s) here:

☐

JEB & JP\CD
to initial

I need more space to write my terms and instructions.

Attach any additional pages to this form and tick the box to indicate that extra pages are attached.

SECTION 7: DECLARATIONS AND SIGNATURES

PRINCIPAL'S SIGNATURE

As the principal you must sign this part in front of an eligible witness.

Refer to section 7, pages 14–15 of Form 10 — Advance health directive explanatory guide and the *Queensland Capacity Assessment Guidelines 2020*.

An eligible witness must be a:

- **justice of the peace (JP)**
- **commissioner for declarations**
- **lawyer**
- **notary public.**

The witness must not be:

- **the person signing for you**
- **your attorney (e.g. under an advance health directive or enduring power of attorney)**
- **someone related to you or related to your attorney**
- **a paid carer or health provider for you (i.e. your health provider)**
- **a beneficiary under your will.**

By signing this document, I confirm that:

- **I am making this advance health directive freely and voluntarily.**

AND

- **I understand the nature and effect of this advance health directive including:**
  - **the nature and likely effects of each direction in this advance health directive**
  - **that a direction operates only while I do not have capacity for the health matter covered by the direction**
  - **that I may revoke a direction at any time I have the capacity to make a decision about the health matter covered by the direction**
  - **that at any time I do not have capacity to revoke a direction, I will be unable to effectively oversee the implementation of the direction.**

AND

- **I understand that if I am appointing an attorney(s) for health matters that:**
  - **I may specify or limit my attorney(s)' power and instruct my attorney(s) about the exercise of the power**
  - **the power given to my attorney(s) begins when I lose capacity to make decisions for health matters**
  - **once my attorney(s)' power begins, my attorney(s) will have full control over, and power to make decisions about, health matters subject to any terms or information included in this advance health directive**
  - **I may revoke the power given to my attorney(s) in this advance health directive at any time I am capable of making an advance health directive giving the same power**
  - **the power I am giving to my attorney(s) continues even if I do not have capacity to make decisions about health matters**
  - **if I am not capable of revoking this advance health directive, I will not be able to oversee the use of the power given to my attorney(s) for health matters.**

ONLY SIGN THIS PART IN FRONT OF AN ELIGIBLE WITNESS

Principal's signature: Janet Byrnes Date: Date

Witness's signature: JP\Cdec Qual (Registration Number) Date: Date

(Witness must also sign page 12)

Person signing for the principal

If you are physically unable to sign this form another person who is eligible must sign the form for you.

Refer to section 7, page 15 of Form 10 — Advance health directive explanatory guide.

By signing this document, I confirm that:

- **the principal instructed me to sign this document**
- **I am 18 years or older**
- **I am not a witness for this advance health directive**
- **I am not an attorney of the principal.**

Name			
Address			
Suburb		**State**	**Postcode**

ONLY SIGN THIS PART IN FRONT OF THE PRINCIPAL AND AN ELIGIBLE WITNESS

Person signing for the principal signs here: _____ Date: _____

Witness's signature: _____ Date: _____

WITNESS CERTIFICATE

This part must be filled in and signed by the eligible witness at the same time that you sign the advance health directive.

INFORMATION FOR THE WITNESS

As a witness you are not simply witnessing the principal's signature. You must also be satisfied that the principal appears to have capacity to make the advance health directive.

Refer to section 7, page 16 and pages 20–21 of Form 10 — Advance health directive explanatory guide and the *Queensland Capacity Assessment Guidelines 2020*.

If an interpreter assisted in the preparation of this document or if an interpreter is present when this document is witnessed, complete Form 7 – Interpreter's/translator's statement at www.publications.qld.gov.au

By signing this document, I certify that: *(Tick one box only)*

☑ **the principal signed this advance health directive in my presence**

OR

☐ **in my presence, the principal instructed another person to sign this advance health directive for the principal, and that person signed it in my presence and in the presence of the principal.**

AND

» **I am a:** *(Tick one box only)*

☑ **justice of the peace (JP)**

☑ **commissioner for declarations**

Note: tick the appropriate box only

☐ **lawyer**

☐ **notary public.**

» **I am not:**

- » **the person signing the document for the principal**
- » **an attorney of the principal**
- » **a relation of the principal or relation of an attorney of the principal**
- » **a paid carer or health provider of the principal**
- » **a beneficiary under the principal's will.**

» **I have verified that section 5 of this advance health directive has been signed and dated by a doctor.**

» **At the time of making this advance health directive the principal appears to me to have the capacity to make this advance health directive. The principal appears to:**

- » **understand the nature and effect of this advance health directive**
- » **be capable of making the advance health directive freely and voluntarily.**

This document (including any additional pages) has _____ pages.

Witness's signature: JP/CD Signature **Date:** Date

(Witness must also sign page 11)

Witness's name: JP/CD Name Qualification

Seal of office
JP\CD Reg No

SECTION 8: ATTORNEY(S)' ACCEPTANCE

If you have appointed an attorney(s) under section 6 the attorney(s) must sign this section.

It does not matter which order your attorney(s) sign this section.
Your attorney(s) must sign this section of the original form after you and the witness have signed section 7.

INFORMATION FOR ATTORNEYS

An attorney has important duties and obligations.

Refer to section 8, page 17 and pages 22–24 of Form 10—Advance health directive explanatory guide for further information about the duties and obligations of an attorney.

Note: a paid carer is someone who is paid a fee or wage to care for a person but not someone receiving a carer's pension or benefit.

In signing this advance health directive I accept the appointment in accordance with the terms of this advance health directive and confirm that:

- **I have** read **this advance health directive and I understand that I** must **make decisions and exercise power in accordance with this advance health directive, the** *Powers of Attorney Act 1998* **and the** *Guardianship and Administration Act 2000*.
- **I** understand:
  - **in exercising my powers I must apply the general principles and if I exercise powers for health care matters, the health care principles under the** *Powers of Attorney Act 1998* **and the** *Guardianship and Administration Act 2000*
  - **the obligations of an attorney and the consequences of failing to comply with those obligations.**
- **I** declare **that:**
  - **I have capacity for the matter that I am appointed for**
  - **I am 18 years or older**
  - **I am not a paid carer for the principal**
  - **I am not a health provider for the principal**
  - **I am not a service provider for a residential service where the principal is a resident.**

Signature: _____

Full name: _____ **Date:** _____

Signature: _____

Full name: _____ **Date:** _____

Signature: _____

Full name: _____ **Date:** _____

Signature: _____

Full name: _____ **Date:** _____

☐ **I have appointed an additional attorney(s) and need more space for my attorney(s) to sign.**

Attach any additional pages to this form and tick the box to indicate extra pages are attached.

SECTION 9: WHAT TO DO WITH YOUR COMPLETED ADVANCE

You should:

- **keep the original in a safe place**
- **give a certified copy to your attorney(s) (if appointed), doctor, other health provider(s), bank or lawyer**
- **notify your close family and friends that you have made an advance health directive and where to find the document**
- **review your advance health directive at least every two years or if your health changes significantly.**

Refer to 'Further information' on pages 18–19 of Form 10 — Advance health directive explanatory guide for information on how to make a certified copy and how your advance health directive may be revoked.

My Health Record

If you wish your document to be in My Health Record you can upload it via the My Health Record website at www.myhealthrecord.gov.au. Your document will be valid regardless of whether it is uploaded.

Office of Advance Care Planning

You are able to have your advance health directive uploaded to your Queensland Health electronic record. To do this, send a copy of your document to the Office of Advance Care Planning. This way it will be easily available to authorised clinicians involved in your care when it is required. A copy of your document can be sent to the Office of Advance Care Planning at acp@health.qld.gov.au, PO Box 2274, Runcorn, Queensland 4113 or fax 1300 008 227.

What about registering as an organ donor?

If you are interested in donating your organs after death, visit the Australian Organ Donor Register at donatelife.gov.au