Let Me Decide
Health and Personal Care Directive
New South Wales Version

1. Introduction
In this Directive I am stating my wishes for my health and personal care should the time ever come when I am not able to communicate because of illness or injury. This Directive should never be used if I am able to decide for myself. It must never be substituted for my judgement if I can make these decisions.

If the time comes when I am unable to make these decisions, I would like this Directive to be followed and respected. Please do everything necessary to keep me comfortable and free of pain. Even though I may have indicated that I do not want certain treatments, I recognise that these may be necessary to keep me comfortable.

I understand that my choices may be overridden if a treatment is necessary to maintain my comfort.

I have thought about and discussed my decision with my family, friends and family doctor. In an emergency, please contact my “person responsible” or my family doctor listed over. If these people are not available, then please do as I have requested in this Directive.

I understand that I can revise this Directive at anytime and that it should be reviewed once a year, after an illness or if there is a change in my health. If I need to update the Directive I can fill in a new form otherwise I can endorse the contents by signing again on the last page.

Person(s) Responsible (contact details on page 4 of this document)

I, _______________________________________ (print name), acknowledge that:

① ________________________________ (print name) is my person responsible because they are my (please circle):

i. Enduring guardian, who possesses the legal authority to act, either (please circle):
   (a) separately; or (b) jointly with ______________________________ (print name); or
ii. Spouse / defacto, with who I have a close, continuing relationship; or
iii. Unpaid carer who provides (or previously provided) support to me; or
iv. Relative / friend with whom I have a close personal relationship

If my “person/s responsible” indicated above is/are not available for any reason, declines in writing to exercise their functions, or a medical practitioner or qualified person certifies in writing that the person/s responsible’ is/are not capable for carrying out the functions, then I acknowledge that:

② ________________________________ (print name) becomes my person responsible, according to the hierarchy set by the Guardianship Act, because they are my (please circle):

i. Spouse / defacto, with who I have a close, continuing relationship; or
ii. Unpaid carer who provides (or previously provided) support to me; or
iii. Relative / friend with whom I have a close personal relationship.

** Adapted to NSW context by: Central Sydney Division of General Practice; Centre for Education and Research on Ageing; NSW Guardianship Tribunal; NSW Young Lawyers; Concord Repatriation General Hospital

Source: “Taking Charge” – The Benevolent Society
Author: Dr D. W. Molloy
2. Definitions

A. **Loss of functioning that is NOT acceptable AND NOT reversible**
   An unacceptable and irreversible loss in my ability to function may result from:
   a) An illness or injury that is not reversible and that leaves me with a loss in ability to function that consider to be not acceptable.

B. **Loss of functioning that IS acceptable AND/OR IS reversible**
   An acceptable and/or reversible loss in my ability to function may result from either:
   b) A life threatening illness or injury that is reversible. This is curable, meaning that losses in my ability to function are not permanent. OR
   c) An illness or injury that is not reversible, but that leaves losses in my ability to function that I consider to be acceptable.

C. **Cardiac Arrest (CPR)**

- **CPR**
  Use cardiac massage with mouth-to-mouth breathing; may also include intravenous lines, electric shocks to the heart (defibrillators), tubes in throat to lungs (endotracheal tubes).

- **NO CPR**
  Make no attempt to resuscitate.

D. **Feeding**

- **Basic**
  Spoon-fed with a regular diet. Give all fluids by mouth that can be tolerated, but make no attempt to feed by special diets, intravenous fluids or tubes.

- **Supplemental**
  Give supplements or special diets (eg. high calorie, fat or protein supplements).

- **Intravenous**
  Give nutrients (water, salt, carbohydrate protein and fat) by intravenous infusions.

- **Tube**
  Use tube feeding. There are two main types:
  - **Nasogastric Tube**: a soft plastic tube passed through the nose or mouth into the stomach.
  - **Gastrostomy Tube**: a soft plastic tube passed directly into the stomach through the skin over the abdomen.

E. **Levels of Care**

- **Palliative Care**
  Keep me warm, dry and pain free. Do not transfer to hospital unless absolutely necessary. Only give measures that enhance comfort or minimise pain (eg. morphine for pain). Intravenous line started only if it improves comfort (eg. for dehydration). No x-rays, blood tests or antibiotics unless they are given to improve comfort.

- **Limited Care (includes Palliative)**
  May or may not transfer to hospital. Intravenous therapy may be appropriate. Antibiotics should be used sparingly. A trial of appropriate drugs may be used. No invasive procedures (eg. surgery). Do not transfer to Intensive Care Unit.

- **Surgical Care (includes Limited)**
  Transfer to acute care hospital (where patient may be evaluated). Emergency surgery if necessary. Do not admit to Intensive Care Unit. Do not ventilate (except during and after surgery ie. Tube down throat and connected with machine).

- **Intensive Care (includes Surgical)**
  Transfer to acute care hospital without hesitation. Admit to Intensive Care Unit if necessary. Ventilate me if necessary. Insert central line (ie. main arteries for fluids when other veins collapse). Provide surgery, biopsies, all life support systems and transplant surgery. Do everything possible to maintain life.
3. Health and Personal Care

**Personal Statement.**

I would consider an unacceptable level of functioning for me to include:

____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

**SO,**

If my loss of functioning is **NOT** acceptable **AND** **NOT** reversible
(Definition A.) then please treat me as I have indicated below.

<table>
<thead>
<tr>
<th>Cardiac Arrest (Definition C.)</th>
<th>Life threatening Illness (Definition E.)</th>
<th>Feeding (Definition D.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPR</td>
<td>Intensive</td>
<td>Tube</td>
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<tr>
<td></td>
<td>Limited</td>
<td>Supplemental</td>
</tr>
<tr>
<td></td>
<td>Palliative</td>
<td>Basic</td>
</tr>
</tbody>
</table>

(Write your choice in the box provided)

If my loss of functioning is **ACCEPTABLE** **AND/OR** **IS** reversible,
(Definition B.) then please treat me as I have indicated below

<table>
<thead>
<tr>
<th>Cardiac Arrest (Definition C.)</th>
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</tr>
</tbody>
</table>

(Write your choice in the box provided)

I would agree to the following procedures (write yes or no)  

<table>
<thead>
<tr>
<th>Blood transfusion</th>
<th>Organ transplant</th>
</tr>
</thead>
</table>

In the event of my death, I consent to the following procedures (write yes or no)

<table>
<thead>
<tr>
<th>Organ donation</th>
<th>Post Mortem</th>
<th>Cremation</th>
</tr>
</thead>
</table>
4. Signatures

NOTE: This Directive can either be completed on its own, or in conjunction with Enduring Guardianship forms, available from the NSW Guardianship Tribunal. Phone: 1800 463 928 (toll free) or (02) 9555 8500

Person Completing the Directive
I, ____________________________ (print name)
Of address:

am voluntarily completing this Advance Care Directive document of my own free will on this date: _______________
Signed: ___________________________

Person(s) Responsible
I/we have read, understood and agree to act in accordance with the contents of this Directive:

1). Name  __________________________________________
Signature __________________________________________
Date  ___________________________
Address ___________________________________________________________________________
Ph: (hm)   ________________________________ (wk)  ______________________________

2). Name  __________________________________________
Signature __________________________________________
Date  ___________________________
Address ___________________________________________________________________________
Ph: (hm)   ________________________________ (wk)  ______________________________

3). Name  __________________________________________
Signature __________________________________________
Date  ___________________________
Address ___________________________________________________________________________
Ph: (hm)   ________________________________ (wk)  ______________________________

Enduring Guardian/s
If I have an enduring guardian/s, they were appointed on the date:  _____________________________
And the document is held at:  _______________________________________________________________________

General Practitioner
Name  ________________________________________________________
Signature ____________________________________
Date  ____________________________________
Address __________________________________________________________________________________
Ph: (hm) ____________________________________ (wk) ____________________________________

Witness
I am the witness to this Directive. I verify that _____________________________ (print name of the person completing Directive) signed this Directive on this date: _______________ of his or her own free will, without threats or offered inducements. I am not a relative of the person completing this Directive nor of the person/s responsible and I am not involved in the person’s medical treatment.

Name  ________________________________________________________
Signature ____________________________________
Date  ____________________________________
Address __________________________________________________________________________________
Ph: (hm) ____________________________________ (wk) ____________________________________

Updating this Directive (in 12 months time)
If, after reviewing this document in 12 months time, I wish to endorse the contents, I do so by signing below:
Signature_______________________ Date  ________________

Source: “Taking Charge” – The Benevolent Society
Author: Dr D. W. Molloy