Advance care directive for young people under 18 years of age

For patient record purposes, health services can affix UR number, patient name and date of birth here

made under the *Medical Treatment Planning and Decisions Act 2016* (Vic.)

Any advance care directive that you have previously made under this Act is automatically revoked (cancelled) when you complete this advance care directive.

This form is designed for young people aged under 18 years to complete using the accompanying *Instructions for completing the 'Advance care directive for young people under 18 years of age' form.*

Part 1: Personal details

You must fill in your full name, date of birth and address. A phone number is optional.

Your full name:	
Date of birth: (dd/mm/yyyy)	
Address:	
Phone number:	

If you have no current health problems, cross out this section.

My **current** major health problems are:

It is helpful to know if you have completed an Advance Statement in relation to a mental illness.

Mark with an X if the statement below is relevant to you.

I **have** completed an Advance Statement under the *Mental Health Act 2014* (Vic.).	

VICTORIA State Government

Advance care directive for young people under 18 years of age (cont.)

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Advance care directive of: (insert your full name)	

Part 2: Values directive

Your parent/guardian is legally required to first consider your values directive when making decisions about your medical treatment.

You may complete all, some, or none of the sections.

a) What matters most in my life:
(What does living well mean to you?)

In Part 2 you can write your values and preferences for your medical treatment.

Refer to Part 2 a) of the instructions.

b) What worries me most about my future:

Refer to Part 2 b) of the instructions.

c) For me, unacceptable outcomes of medical treatment after illness or injury are:
(For example, loss of independence, high-level care or not being able to recognise people or communicate)

Part 2 c) of the instructions includes a table with examples of health outcomes to help you complete this section.

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Advance care directive of: (insert your full name)	

Part 2: Values directive (cont.)

d) Other things I would like known are:

Refer to Part 2 d) of the instructions.

Things you can include about your values and preferences are:

- spiritual, religious, or cultural requirements
- your preferred place of care
- treatment with prescription pharmaceuticals (medicine)
- treatment for mental illness
- medical research procedures.

e) Other people I would like involved in discussions about my care:

Refer to Part 2 e) of the instructions.

f) If I am nearing death the following things would be important to me:

Refer to Part 2 f) of the instructions.

Things to consider include: persons present, spiritual care, customs or cultural beliefs met, music or photos that are important.

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Advance care directive of: (insert your full name)	

Part 3: Instructional directive

This instructional directive is legally binding and communicates your medical treatment decision(s) directly to your health practitioner(s). It is recommended that you consult your main medical practitioner if you choose to complete this instructional directive.

- Your instructional directive will only be used if you do not have decision-making capacity to make a medical treatment decision.
- Your medical treatment decisions in this instructional directive take effect as if you had consented to, or refused to, begin or continue medical treatment.
- If any of your statements are unclear or uncertain in particular circumstances, it will become a values directive.
- In some limited circumstances set out in the Act, a health practitioner may not be required to comply with your instructional directive.

Cross out this page if you do not want to consent to or refuse future medical treatment.

Refer to Part 3 of the instructions for more information on how to complete your instructional directive.

Keep in mind:

- you should include details about the circumstances in which you consent to or refuse treatment
- health practitioners can only offer treatment that is medically appropriate
- in an end-of-life care situation, certain medical interventions may be required for organ and tissue donation to take place.

a) I consent to the following medical treatment:
(Specify the medical treatment and the circumstances)

b) I refuse the following medical treatment:
(Specify the medical treatment and the circumstances)

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Advance care directive of: (insert your full name)	

Part 4: Expiry date (optional)

Only complete this part if you want this advance care directive to have an expiry date. Refer to Part 4 of the instructions.

This advance care directive expires on: (dd/mm/yyyy)	

Part 5: Witnessing

You must sign in front of two adult witnesses.

One witness must be a child and adolescent psychiatrist OR a clinical psychologist or clinical neuropsychologist with special qualifications and experience.

Refer to Part 5 of the Instructions for more information on the training and experience requirements for witnessing this form.

It is highly recommended that the other witness is your main treating doctor.

It is recommended that you discuss your advance care directive with the witnesses and your treating medical practitioners together. This will ensure your witnesses can be satisfied that you understand the medical implications of your advance care directive.

Signature of person giving this directive (you sign here)

Each witness certifies that:

- at the time of signing the document, the person giving this advance care directive appeared to have decision-making capacity in relation to each statement in the directive and appeared to understand the nature and effect of each statement in the directive; and
- the person appeared to freely and voluntarily sign the document; and
- the person signed the document in my presence and in the presence of the second witness; and
- I am not the parent or guardian of the person.

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Advance care directive of: (insert your full name)	

Witness 1 – Registered medical practitioner

A child and adolescent psychiatrist must complete this part of the form.

If your first witness is a registered psychologist with special qualifications and training, cross out this section.

Full name of registered medical practitioner:

Qualification and AHPRA registration number of registered medical practitioner:

In addition to a current Fellowship of the Royal Australian and New Zealand College of Psychiatrists, I also:
(mark with an X; at least one must apply)

Hold a Certificate of Advanced Training in Child and Adolescent Psychiatry awarded by the Royal Australian and New Zealand College of Psychiatrists;	
Am a current accredited member of the Faculty of Child and Adolescent Psychiatry of the Royal Australian and New Zealand College of Psychiatrists	

Signature of registered medical practitioner:	Date: (dd/mm/yyyy)

OR

Witness 1 – Registered psychologist

A clinical psychologist or clinical neuropsychologist must complete this part of the form.

If your first witness is a registered medical practitioner with the prescribed qualifications and training, cross out this section.

Full name of registered psychologist

Qualification and AHPRA registration number of registered psychologist:

I am endorsed by Psychology Board of Australia as a:
(mark one with an X)

Clinical psychologist	
Clinical neuropsychologist	

Name of health service where you provide specialist paediatric care:

Signature of registered psychologist:	Date: (dd/mm/yyyy)

For patient record purposes, health services can affix UR number, patient name and date of birth here

Advance care directive of: (insert your full name)	

Another adult witness must complete this part of the form. **It is highly recommended that this witness is your main treating doctor.** The witness cannot be your parent/guardian.

Witness 2 – Adult witness

Full name of adult witness:

Signature of adult witness: Date: (dd/mm/yyyy)

If an interpreter is present at the time the document is witnessed, they complete this section immediately after the document is witnessed.

If an interpreter is present when this document is witnessed

Name of interpreter:

If accredited with the National Accreditation Authority

NAATI number:	

I am competent to interpret from English into the following language:

I provided a true and correct interpretation to facilitate the witnessing of the document.

Signature of interpreter: Date: (dd/mm/yyyy)

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Advance care directive of: (insert your full name)	

Part 6: Interpreter statement

If an interpreter assisted in the preparation of this document

If an interpreter helped you to prepare this document, they complete this section.

They can fill in this section before the document is witnessed or at the time the document is witnessed.

Refer to Part 6 of the instructions.

Name of interpreter:

If accredited with the National Accreditation Authority

NAATI number:	

I am competent to interpret from English into the following language:

When I interpreted into this language the person appeared to understand the language used in the document.

Signature of interpreter:	Date: (dd/mm/yyyy)

You have reached the end of this form.

It is recommended that you **review your advance care directive annually**, or whenever there is a change in your personal or medical situation.

- Please keep your original advance care directive safe and accessible for when it is needed.
- Ensure that your medical treatment decision maker (if any) has read and understood its contents.
- Your advance care directive can be uploaded on My Health Record and should be shared with your medical treatment decision maker and relevant health practitioner(s) / health service(s).