PROMPT LEGAL SERVICES
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This form provided by_____Date : ___/___/201__
This form Returned on Date : ___/___/201__

INSTRUCTIONS FOR APPOINTMENT OF MEDICAL TREATMENT DECISION MAKER

(inc ADVANCED CARE DIRECTIVE)

Principal (Person giving the power):

NAME:	
ADDRESS:	
DATE OF BIRTH:	
OCCUPATION:	
PHONE NUMBER:	

Medical treatment decision maker 1:

NAME:	
ADDRESS:	
DATE OF BIRTH:	
OCCUPATION:	
PHONE NUMBER:	
RELATIONSHIP:	

Medical treatment decision maker 2:

NAME:	
ADDRESS:	
DATE OF BIRTH:	
OCCUPATION:	
PHONE NUMBER:	
RELATIONSHIP:	

Limitations

☐ None

Interpreter required? ☐ Yes ☐ No

Advanced Care directive: (OPTIONAL)

Major Health Problems:

What matters most in your life: *(What does living well mean to you?)*

What worries me most about my future?

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)

Other things I would like known are:

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

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

Organ tissue donation ☐ Yes ☐ No

I consent to the following medical treatment:

I refuse the following medical treatment:

Expiry date of these directives: _____/_____/201__