END OF LIFE
ADVANCED CARE DIRECTIVE

Basically, I want the right to make my own choices about living my life now and on the journey to the FINAL CHAPTER and in due course THE END.
Especially if I am left in a state of lingering ill-health, debilitation and dependence on the good will of others.
Here, I wish to state that if it becomes legal and there will be no blame attributed to others who assist me I wish my life to be ended if there is no hope of recovery and returning health. I wish the right to choose to do this when I deem it right for me!
I would prefer to gather my loved ones around me and bid them farewell in a calm and relaxed atmosphere than to linger.....
PARTY FIRST OF COURSE!!!

I know of people who have committed suicide because they were in too much pain for them to bear any longer. They had had enough! An ugly, painful solution for everyone concerned. They would have preferred an easy crossing over (end to life) with family and friends partying, saying goodbye, etc. Instead they must hide their feelings and intentions and die alone so loved ones cannot be prosecuted by the legal system. WE ARE KINDER TO OUR PETS!!
It's interesting that if we treated our pets this way we would be prosecuted for cruelty to animals????

AT THE PRESENT, I WOULD RATHER BE TREATED BY A VET!!

Marija Rosa
Aka Mara
Dated 6 March 2018

END OF LIFE
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The form I have lists no options.

Is it necessary to spend so much time at the Doctor's to fill in forms.?
Is it necessary for the doctor to fill in the form? I am currently being told that the doctor is the one who has to fill in the form is that true?

I do not remember where I got the form but do remember I did not find it where I expected and had to spend a lot of time going here and there to find it.

These forms should be easily accessible.

They should also be easily understood.

I believe they should also list more option (scenarios) because when you are making these decisions you need as much information as you can readily absorb to base your decisions on.

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ADVANCE CARE DIRECTIVE

This form details my treatment choices if and when I am too sick to make my own choices and I hope my doctors, nurses and family are able to abide by them. It keeps me in control of my life and may relieve my family and carers of having to make difficult decisions on my behalf. At the time of writing I am of sound mind and understand the implications of this document. If I have declined a treatment, I am fully aware that it may shorten my life and I choose these options because I do not want it to be prolonged by medical intervention. If my choices cause me pain or distress I request strong pain killers, sedatives and similar palliative treatment to help relieve my symptoms.

Full Name

Date of Birth

Address

Signature **Today's Date**

Witness's Name and Signature (a friend or neighbour but not a family member or your Doctor)

HOW TO COMPLETE THE FORM

Write in each box YES or NO

To refuse a treatment NO

To agree to a treatment YES

ADVANCE CARE DIRECTIVE

B PREFERENCES, LIFE GOALS, VALUES AND BELIEFS:

Imagine you were admitted to hospital tonight and you were seriously unwell with perhaps a severe stroke, overwhelming infection, major head injury, or multiple organ failure and you were unable to make any decisions. It would be a good idea to make a 'preference statement' to guide your doctor's and family as to what outcome would be unacceptable to you. Write YES in the following statements if you agree and add one of your own if you have special circumstances: For example, if you have severe emphysema, motor neurone disease, cancer, MS or some other debilitating condition.

Important Points to consider: Consider points important to you such as being able to get around by yourself, being able to recognise & communicate with people who are significant to you, being able to wash or feed yourself , having control of your bladder & bowels, being able to remain in your own home, your dignity, your religious beliefs and previous experiences.

MY PREFERENCES ARE: **YES or NO**

It would be unacceptable to me if I lost
My independence to the extent I could no
Longer live in my own home.

I would rather die in my home than in a hospital.

Write your own preferences here:
It would be unacceptable to me if....

ADVANCE CARE DIRECTIVE

C IN MY PRESENT HEALTH AND I AM ADMITTED TO HOSPITAL

In my present state of health and sound mind, and I am admitted to hospital through ill health and I cannot express my needs, then my treatment choices in three very different scenarios are:

Cardio-pulmonary Resuscitation (CPR) or life Support (artificial ventilation) to save my life If it looks like my level of functioning will be acceptable to me and/or the illness is reversible and Iam likely to be back to my former self and health.	**YES or NO**
Cardio-pulmonary Resuscitation (CPR) or life Support (artificial ventilation) to save my life Even if the level of functioning is not acceptable to me and my illness cannot be reversed.	**YES or NO**
If I suffer a severe stroke (or similar) and after 2 to 3 weeks i cannot communicate my needs and cannot swallow then I want to be fed by stomach, nasal or intravenous tube (PEG, Nasogastric or IV). I would want renal dialysis or a pacemaker if needed.	**YES or NO**

Important Points to consider:

In this situation, you would probably only say NO to cardio-pulmonary(CPR) if you had decided that for life meaningful you have a certain level of function or that you would be happy to die peacefully at this point in your life.

If you said no to artificial feeding, you would die within a short time, but this may be your intention as the chances of recovery are poor. Where you choose NO, the focus of care will be to keep you comfortable and pain free.

ADVANCE CARE DIRECTIVE

D SEVERE DEMENTIA

If through Alzeimer's disease, stroke, cancer or any other cause my mental state had seriously deteriorated to the extent that i no longer live at home and i am in a nursing home, hostel or hospital and all the following were true:
I could no longer follow a simple conversation.
I could not shower myself without instruction.
I could not describe what a toilet was used for.
I may still be able to walk.

If it were felt there was little chance of recovery then I would make the following treatment choices:

TREATMENTS	YES or NO
Any treatment to prolong my life.	
Antibiotics for life threatening illness.	
Blood pressure, Cholesterol, and Blood thinning tablets.	
Operation for a fractured hip.	
Other operations requiring general or spinal Anaesthetic.	
If I said NO to operations but my pain management cannot be adequately controlled with strong analgesia after 3 days, I would then consent to an operation.	
Intravenous drip for fluid or drugs.	
Immunisations for flu/pneumonia.	
Nutritional supplements to counter weight loss and make you live longer.	
If I am on dialysis or have a pacemaker or a defibrillator I want these treatments continued.	

ADVANCE CARE DIRECTIVE

E TREATMENTS	YES or NO
Antibiotics for life-threatening illness (e.g. pneumonia/septicaemia.) Drugs for BP, Cholesterol & Blood thinning. Immunisations and Nutritional supplements.	
Operation requiring general or spinal anaesthetic.	
If I'm on dialysis or have a pacemaker or a defribillator i want these treatments continued.	

Important points to consider:

If you have deteriorated to this condition you would be completely dependent on 24 hour nursing care for all your bodily functions. Without the presence of a major illness, you may live like this between 12 months and three years, sometimes longer. It can be very difficult for doctors, nurses and close relatives to decide how much treatment you should be given at this stage, particularly if stopping treatment or feeding may lead to early death.

If these issues are discussed with your family in advance there can be little question as to your intentions. Where you choose NO, THE FOCUS WILL BE TO KEEP YOU COMFORTABLE AND PAIN-FREE.

ADVANCE CARE DIRECTIVE

F IF I AM ADMITTED TO A NURSING HOME OR HOSTEL YES or NO

If at any time I too mentally confused to make decisions and become seriously ill whilst I am in a nursing home, I would prefer to be treated in the Nursing Home rather than being transferred to Hospital

G GP, Family Doctor or Specialist to fill in this Section:

I, Dr. _____ CONFIRM THAT_____ (patient's name) understands the implications of this document, in particular (tick box)

1. **They have filled in the form correctly, completely and signed/dated.**
2. **They understand the consequences of their decisions.**

Dr's Signature, Date and Stamp

Signed_____
Date_____
Stamp

REVIEW, SIGN AND DATE EVERY 2-4 YEARS
Photocopies for Patient, Doctor, (& Nursing Home)