PALPRAC

The Association of Palliative Care Practitioners of SA
215-486 NPO
https://palprac.org/

Advance Health Directive

I,_____, being of sound mind, hereby state my wishes concerning medical care in the event that illness or any form of incapacity which may cause me to become incapable of expressing such wishes.

I confirm that I have discussed my wishes with my family practitioner, my next-of-kin/life partner and specifically with those people nominated and named below as my chosen representatives.

Should I become ill with any medical condition from which, in the considered opinion of my medical attendants, there is no hope of recovery to the extent where I may be able to continue my life with a reasonable degree of independence and dignity, such that the expected quality of life following recovery would be acceptable to any reasonable adult person, I request that:

1. No form of medical therapy be instituted or perpetuated for the sole purpose of sustaining or prolonging life;

2. In consultation with my next of kin as nominated below, life support therapy upon which I am wholly dependent for my vital functions, be withdrawn in such a manner that I am allowed to die with dignity equal to that with which I have lived my life;

3. My preferred place of care is My home/hospital/hospice/specify_____

4. I appoint _____as my healthcare primary spokesperson and representative, and request that he/she be consulted concerning all decisions regarding my end-of-life care, and his/her wishes be respected as being in my best interests. Should he/she not be able to attend to my interests for any reason whatsoever, I nominate _____to jointly confer with my medical attendants in order to execute my wishes as set out in the above two paragraphs. Should any of the above-named not be willing or available to act in this manner, I nominate the following named individual_____ to act on behalf of all;

5. In the event of my death, my remains are to be buried / cremated in accordance with _____tradition.

6. Additional instructions with regard to religious, cultural or other beliefs to be respected at all stages of my final ilness

_____

_____

Signature _____ (Patient Signature)

Signed and witnessed at _____ on _____of _____20____

_____ ID_____
(Print name)

Witnessed by:

1. _____ 2. _____

_____ _____
(Print name) (Print name)