Advance Healthcare Directive

An Advance Healthcare Directive is a statement made by you, as a competent adult, relating to the type and extent of medical treatments and care you would or would not want to receive in the future should you be unable to express your wishes at that time. The commonly used term 'Living Will' refers specifically to a written advance healthcare directive. This statement is a legally recognised document under the Assisted Decision Making (Capacity) Act 2015, as amended.

It must be stressed that an Advance Healthcare Directive is not asking doctors or nurses to do anything illegal — it is NOT a request for euthanasia. It is everyone's right to accept or refuse medical treatment. And, if death results from the withholding or withdrawing of life-sustaining treatment, it will not be considered as a suicide.

Your decision to refuse healthcare treatment is legally binding and must be complied with provided the following three conditions are met:

1. You lack capacity to give consent to the treatment at the appropriate time;
2. the treatment to be refused is identified in the directive; and
3. the circumstances, in which the refusal of treatment is intended to apply, are identified in the directive

The form that follows also includes the appointment of a designated healthcare representative to act on your behalf within the scope of the directive. This appointment is optional.

For a more comprehensive coverage on this subject you should visit decisionsupportservice.ie and go to Your Guide to an Advance Healthcare Directive.

This model directive is based on, but not a direct copy of, the template provided by the Office of Decision Support Service.

SECTION 1

Details of the person making the advance healthcare directive (the directive-maker)

(Full name in capitals) ______________________________

of (full address) ______________________________

____

Date of birth ______________________________

Phone number ______________________________

e-mail address ______________________________

SECTION 2

Healthcare treatments I do not want to receive (the directive-maker)

Details must be completed.

Specific treatment I do not want to receive

Specific circumstances in which this refusal is to apply

Please tick one of the following boxes

☐ I want this to apply even if my life is at risk because of this refusal

☐ I do not want this to apply if my life is at risk because of this refusal

Specific treatment I do not want to receive

Specific circumstances in which this refusal is to apply

Please tick one of the following boxes

☐ I want this to apply even if my life is at risk because of this refusal

☐ I do not want this to apply if my life is at risk because of this refusal

Specific treatment I do not want to receive

Specific circumstances in which this refusal is to apply

Please tick one of the following boxes

☐ I want this to apply even if my life is at risk because of this refusal

☐ I do not want this to apply if my life is at risk because of this refusal

Specific treatment I do not want to receive

Specific circumstances in which this refusal is to apply

Please tick one of the following boxes

☐ I want this to apply even if my life is at risk because of this refusal

☐ I do not want this to apply if my life is at risk because of this refusal

Specific treatment I do not want to receive

Specific circumstances in which this refusal is to apply

Please tick one of the following boxes

☐ I want this to apply even if my life is at risk because of this refusal

☐ I do not want this to apply if my life is at risk because of this refusal

SECTION 3

Healthcare treatments I would like to receive

I understand that any request for treatment is not legally binding but is a valid expression of my will and preferences. This request shall be taken into consideration.
Details must be completed.

Specific treatment I would like to receive.

The circumstances in which I would like this request for treatment to apply

---

Specific treatment I would like to receive.

The circumstances in which I would like this request for treatment to apply

---

Specific treatment I would like to receive.

The circumstances in which I would like this request for treatment to apply

---

Specific treatment I would like to receive.

The circumstances in which I would like this request for treatment to apply

---

Specific treatment I would like to receive.

The circumstances in which I would like this request for treatment to apply

---

SECTION 4

Designated health care representative (optional)

Part A must only be completed if you are appointing a designated healthcare representative to act as your agent in accordance with your will and preferences as set out in this directive. If you are not appointing a designated healthcare representative please go to Section 5.

Part B must also be completed if you are appointing an alternative designated healthcare representative to act as your agent in accordance with your will and preferences as set out in this directive. If you are not appointing an alternative designated healthcare representative please go to Section 5.

Part A: details of your designated healthcare representative

I wish to appoint: ______________________________

Name in capitals ______________________________

Date of birth ______________________________

Postal address ______________________________

Phone number ______________________________

e-mail address ______________________________

Part B: details of the alternate designated health care representative

I wish to appoint: ______________________________

Name in capitals ______________________________

Date of birth ______________________________

Postal address ______________________________

Phone number ______________________________

e-mail address ______________________________

Specific powers of designated healthcare representative and alternate designated health care representative.

In addition to ensuring that the terms of my directive are complied with I give the following specific powers to my designated healthcare representatives:

to advise and interpret my will and preferences regarding treatment by reference to the detail as set out in this directive

I want them to have these powers ☐ Yes

To consent to or refuse treatment, up to and including life sustaining treatment based on my known will and preferences by reference to the detailer set out in this directive.

I want them to have these powers ☐ Yes

SECTION 5

Signatures and declarations

This directive must be signed:

• by you (Part A); or
• the person signing on your behalf (Part B);
• the designated healthcare representative (if you have appointed one) (part C);
• the alternative designated health care representative (if you have appointed one) (Part C); and
• two witnesses (Part D).

Each signatory must have attained the age of 18 years, and of whom at least one is not an immediate family member.

For this purpose, your immediate family member is:
• your spouse, civil partner or cohabitant;
• child son-in-law or daughter-in-law;
• parent, step-parent, mother-in-law or father-in-law;
• brother, sister, step-brother, step-sister, brother-in-law or sister-in-law;
• grandparent or grandchild;
• aunt or uncle; or
• nephew or niece.

All parties who are required to sign must do so in each other’s presence.

PART A

You, the directive-maker.

Print name:

____

I confirm I am of sound mind and not suffering from any mental or physical condition which impairs my capacity to make the healthcare decisions described in this document.

I make this directive of my own free will and without pressure or influence from anybody.

If the time comes when I lack the capacity to give directions for my medical care, this document should be considered as my advance directive on how I wish to be treated based on my own values, wishes and beliefs.

I wish it to be understood that I fear degeneration, prolonged dependence and an inability to communicate far more than I fear death itself. I ask my doctors and nurses to bear this statement in mind when considering what my intentions would be in any uncertain situation (please delete, and initial this paragraph if you do not agree with it.)

Signed: ____

Dated: ____

PART B

An advanced healthcare directive may be signed on your behalf by a person who has attained the age of 18 years and who is not one of the witnesses if:

- you are unable to sign the directive;
- you are present and direct that the directive be signed on your behalf by that person; and
- the signature of the person is witnessed.

No one can sign your advanced healthcare directive without your express instruction.

The person directed to sign on my behalf and with my express instruction:

Print name:

____

I confirm that I am making this advanced healthcare directive freely and not under pressure to do so.

I confirm that ____ is signing this directive

on my behalf (Directive-makers name) ____ in the presence of my designated healthcare representative (if appointed) and/or my alternate designated health care representative (if appointed) and 2 witnesses as required.

Signature of person directed to sign on my behalf:

____

I have signed this in the presence of the directive-maker under their instruction.

Dated: ____

PART C

Designated healthcare representative

These details must be completed if you are appointing designated healthcare representative.

I confirm that I agree to act in accordance with the will and preferences of

insert directive-makers name ______________________________

as set out in this advanced healthcare directive.

Print name: ______________________________

Signature: ______________________________

Date: ______________________________

Alternate designated healthcare representative

These details must be completed if you are appointing an alternate designated healthcare representative.

I confirm that I agree to act in accordance with the will and preferences of

insert directive-makers name ______________________________

as set out in this advance healthcare directive, in the event that the original appointed designated health care representative is unable to act.

Print name: ______________________________

Signature: ______________________________

Date: ______________________________

PART D

Witnesses

I confirm that I have witnessed the signing of this advanced healthcare directive by the following in the presence of each other (delete if not applicable):

- the directive-maker ______________________________
- the person signing on behalf of and in the presence of directive-maker ______________________________
- the designated health care representative if appointed ______________________________
- the alternative designated healthcare representative if appointed ______________________________

First witness

Signature: ______________________________

Name: ______________________________

Relationship to the directive-maker: ______________________________

Date: ______________________________

Second witness

Signature: ______________________________

Name: ______________________________

Relationship to the directive-maker: ______________________________

Date: ______________________________

Copies of this Advance Healthcare Directive have been given to the following (e.g. your GP, Health Care Proxy, Spouse, Best Friend, Solicitor):

Name: ______________________________ Telephone: ____________________

Address: ____

Name: ______________________________ Telephone: ____________________

Address: ____

Name: ______________________________ Telephone: ____________________

Address: ____

Organ donation (Optional)

In the event of my death, in the hope that I may help others, I have placed my initials next to the following part(s) of my body that I wish donated for the purpose I have initialled below:

- ☐ Any organs or part
- ☐ Eyes
- ☐ Bone and connective tissue
- ☐ Liver
- ☐ Heart
- ☐ Kidney(s)
- ☐ Lung(s)
- ☐ Pancreas

For the purposes of:

- ☐ Any purpose authorised by law
- ☐ Transplantation
- ☐ Research
- ☐ Medical education

(Your signature and date)

Review dates

This Advance Healthcare Directive was reviewed and confirmed by me as not requiring any change on the following dates (ideally it should be reviewed every 3 years):

Your signature ______________________________ ______________
(Date)

Your signature ______________________________ ______________
(Date)

Your signature ______________________________ ______________
(Date)

Your signature ______________________________ ______________
(Date)

Your signature ______________________________ ______________
(Date)

(You have the right to change or cancel this Healthcare Directive at any time. If you do, you must advise everyone who has a copy that you have done so. If you make any major changes, it is naturally advisable to write a new Advance Healthcare Directive. Otherwise, all minor amendments to this documents must be signed by you, and dated.)