醫院管理局
HOSPITAL AUTHORITY

ADVANCE DIRECTIVE
(TO REFUSE CARDIOPULMONARY RESUSCITATION WHEN SUFFERING FROM TERMINAL ILLNESS)

Please Use Block Letter or Affix Label

SOPD / Hospital No. : ……..

Name: ……..…….

I.D. No: ……...Sex ……Age……...

Dept: …….Team:…..…Ward/Bed:…./……

Section I: Personal Details of the Maker of this Advance Directive

Name: ..... Identity Document No.: ……

Sex: ..... Date of Birth: ……... Tel. No.: ……..

Home Address: ……

Section II: The Directive

1. I, _____, being over the age of 18 years, revoke all previous advance directives made by me relating to my medical care and treatment (if any), and make the following advance directive of my own free will.

2. If I am **terminally ill**[#] as diagnosed by my attending doctor and at least one other doctor, so that I am unable to take part in decisions about my medical care and treatment, my directive in relation to my medical care and treatment is as follows:
   I shall not be given cardiopulmonary resuscitation (CPR).

3. I make this directive in the presence of the two witnesses named in Section III of this advance directive, who are not beneficiaries under my will, or any policy of insurance held by me, or any other instrument made by me or on my behalf.

4. I understand I can revoke this advance directive at any time.

_____ _____

(Signature of the maker of this advance directive) (Date)

[#] "Terminally ill" means suffering from advanced, progressive, and irreversible disease, and failing to respond to curative therapy, having a short life expectancy in terms of days, weeks or a few months; and the application of life-sustaining treatment would only serve to postpone the moment of death.

Section III: Statement of Witnesses

Notes for witness: A witness must be a person who is not a beneficiary under the will of the maker of this advance directive, or any policy of insurance held by the maker of this advance directive, or any other instrument made by or on behalf of the maker of this advance directive.

First Witness (Note: This witness must be a registered medical practitioner)

1. I, _____ *(please print name)* sign below as witness.
   i. As far as I know, the maker of this directive has made the directive voluntarily; and
   ii. I have explained to the maker of this directive the nature and implications of making this directive.
2. I declare that this directive is made and signed in my presence together with the second witness named below.

_____ _____
(Signature of 1st witness) (Date)

Name: ……
Identity Document No. / Medical Council Registration No.[1]: ……..
Office Address: ……
……..
Office Tel. No.: ……..

Second Witness (Note: This witness must be at least 18 years of age)

1. I, _____ *(please print name)* sign below as a witness.
2. I declare that this directive is made and signed in my presence together with the first witness named above, and that the first witness has, in my presence, explained to the maker of this directive the nature and implications of making this directive.

_____ _____
(Signature of 2nd witness) (Date)

Name: …….
Identity Document No.[2]: ……
Home Address / Contact Address: …….
……
Home Tel. No. / Contact No. : ……...

[1] It is not necessary for HA staff to provide the Identity Document No. / Medical Council Registration No. since staff code or address of hospital ward/ unit would be sufficient for the identification of the 1st witness.

[2] It is not necessary for HA staff to provide the Identity Document No. since staff code or address of hospital ward/ unit would be sufficient for the identification of the 2nd witness.