



ADVANCE DIRECTIVE¹

Please Use Block Letter or Affix Label

SOPD / Hospital No. :

Name :

I.D. No :SexAge.....

Dept :Team :.....Ward/Bed :.../.....

Section I : Personal details of the maker of this advance directive

Name : _____ (please use capital letters)

Identity Document No.: _____

Sex : Male / Female

Date of Birth : ____ / ____ / ____
(Day) (Month) (Year)

Home Address : _____

Home Tel. No. : _____

Office Tel. No. : _____

Mobile Tel. No. : _____

Section II : Background

1. I understand that the object of this directive is to minimise distress or indignity which I may suffer or create when I am terminally ill or in a persistent vegetative state or a state of irreversible coma, or in other specified end-stage irreversible life limiting condition, and to spare my medical advisers or relatives, or both, the burden of making difficult decisions on my behalf.
2. I understand that euthanasia will not be performed, nor will any unlawful instructions as to my medical treatment be followed in any circumstances, even if expressly requested.
3. I, _____ (please print name) 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.
4. If I become terminally ill or if I am in a state of irreversible coma or in a persistent vegetative state or in other specified end-stage irreversible life limiting condition 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 directives in relation to my medical care and treatment are as follows:

(Note: Complete the following by ticking the appropriate box(es) and writing your initials against that/those box(es), and drawing a line across any part you do not want to apply to you.)

¹ The Form was proposed by the Law Reform Commission on 16 August 2006; amended as in Food and Health Bureau Consultation Paper on 23 December 2009; further modifications made and footnotes added by the Hospital Authority.

(A) Case 1 – Terminally ill

(Note: In this instruction –

"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, and

"Life-sustaining treatment" means any of the treatments which have the potential to postpone the patient's death and includes, for example, cardiopulmonary resuscitation, artificial ventilation, blood products, pacemakers, vasopressors, specialised treatments for particular conditions such as chemotherapy or dialysis, antibiotics when given for a potentially life-threatening infection, and artificial nutrition and hydration. (Artificial nutrition and hydration means the feeding of food and water to a person through a tube.)

I shall not be given the following life-sustaining treatment(s):

Cardiopulmonary resuscitation (CPR)

Others: _____

Save for basic and palliative care, I shall not be given any life-sustaining treatment². The offer of oral nutrition and hydration shall, for the purposes of this form, form part of basic care.

However, I want to continue to receive artificial nutrition and hydration, if clinically indicated, until death is imminent and inevitable.

(B) Case 2 – Persistent vegetative state or a state of irreversible coma

(Note: In this instruction -

"Life-sustaining treatment" means any of the treatments which have the potential to postpone the patient's death and includes, for example, cardiopulmonary resuscitation, artificial ventilation, blood products, pacemakers, vasopressors, specialised treatments for particular conditions such as chemotherapy or dialysis, antibiotics when given for a potentially life-threatening infection, and artificial nutrition and hydration³. (Artificial nutrition and hydration means the feeding of food and water to a person through a tube.)

I shall not be given the following life-sustaining treatment(s):

Cardiopulmonary resuscitation (CPR)

Others: _____

Save for basic and palliative care, I shall not be given any life-sustaining treatment⁴. The offer of oral nutrition and hydration shall, for the purposes of this form, form part of basic care.

However, I want to continue to receive artificial nutrition and hydration, if clinically indicated, until death is imminent and inevitable.

² Care should be taken to ensure that the patient has really decided not to consent to receive "all" life-sustaining treatment.

³ Note that to withdraw artificial nutrition and hydration (ANH) in a non-terminally ill patient who is in a persistent vegetative state or a state of irreversible coma (PVS/IC) can be contentious even in the presence of an AD. For patients presenting with such a directive and in PVS/IC, advice should be sought from the HCE/CCE and HAHO to consider whether an application to the Court is required. A patient wishing to make a directive to withdraw ANH, or to withdraw all life-sustaining treatments under this Section, should be alerted about this special caution.

⁴ Care should be taken to ensure that the patient has really decided not to consent to receive "all" life-sustaining treatment.

(C) **Case 3 – Other end-stage irreversible life limiting condition, namely:**

(Note: In this instruction -

"Other end-stage irreversible life limiting condition" means suffering from an advanced, progressive, and irreversible condition not belonging to Case 1 or Case 2, but has reached the end-stage of the condition, limiting survival of the patient. Examples include:

- (1) patients with end-stage renal failure, end-stage motor neuron disease, or end-stage chronic obstructive pulmonary disease who may not fall into the definition of terminal illness in Case 1, because their survival may be prolonged by dialysis or assisted ventilation, and
- (2) patients with irreversible loss of major cerebral function and extremely poor functional status who do not fall into Case 2.

"Life-sustaining treatment" means any of the treatments which have the potential to postpone the patient's death and includes, for example, cardiopulmonary resuscitation, artificial ventilation, blood products, pacemakers, vasopressors, specialised treatments for particular conditions such as chemotherapy or dialysis, antibiotics when given for a potentially life-threatening infection, and artificial nutrition and hydration. (Artificial nutrition and hydration means the feeding of food and water to a person through a tube.)

I shall not be given the following life-sustaining treatment(s):

Cardiopulmonary resuscitation (CPR)

Others: _____

Save for basic and palliative care, I shall not be given any life-sustaining treatment⁵. The offer of oral nutrition and hydration shall, for the purposes of this form, form part of basic care.

However, I want to continue to receive artificial nutrition and hydration, if clinically indicated, until death is imminent and inevitable.

5. I make this directive in the presence of the two witnesses named in Section III of this advance directive, who are not beneficiaries under:

- (i) my will; or
- (ii) any policy of insurance held by me; or
- (iii) any other instrument made by me or on my behalf.

6. I understand I can revoke this advance directive at anytime⁶.

Signature of the maker of this advance directive

Date

Section III : Witnesses

Notes for witness :

A witness must be a person who is not a beneficiary under –

- (i) the will of the maker of this advance directive; or
- (ii) any policy of insurance held by the maker of this advance directive; or
- (iii) any other instrument made by or on behalf of the maker of this advance directive.

⁵ Care should be taken to ensure that the patient has really decided not to consent to receive "all" life-sustaining treatment.

⁶ A written revocation can be directly signed on the advance directive form, or written and signed on a separate piece of paper and attached to the advance directive form.

Statement of Witnesses

First Witness

(Note: This witness must be a registered medical practitioner, who, at the option of the maker of this directive, could be a doctor other than one who is treating or has treated the maker of this directive.)

- (1) I, _____ (please print name) sign below as witness.
 - (a) as far as I know, the maker of this directive has made the directive voluntarily; and
 - (b) 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.⁷:

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 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.⁸:

Home Address / Contact Address :

Home Tel. No. / Contact No. :

⁷. 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.

⁸. 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.