ADVANCE HEALTH CARE DIRECTIVE

of the

Cancer Association of South Africa (CANSA

Introduction
This document is made available so that an adult individual can give specific instructions about any aspect of his/her health care. Choices are provided for the person completing this document to express his/her wishes regarding the provision, withholding, or withdrawal of treatment to keep him/her alive, as well as the provision of pain relief. Space is also provided for the individual to add to the choices they have made or to write out any additional wishes. This form also lets the individual express an intention to donate his/her bodily organs and/or tissues following his/her death. Lastly, this form makes provision for the individual to designate a physician to have primary responsibility for his/her health care.

After completion of this form, all signatories to this Advance Health Care Directive must sign the document in the space provided as well as initial every single page of the document. The document must also be signed by two qualified witnesses or acknowledged before a Notary Public or Commissioner of Oaths. A certified copy of the signed and completed Advance Health Care Directive should be provided to the elected primary care physician, to any other health care provider(s) the individual may have indicated, to any health care institution at which the individual normally receives care, and to any health-care agent(s) the individual may have named.

I

_____
[Full Name(s) and Surname]

being of sound mind and at least 18 years of age, declare that:

1. End-of-Life-Decisions
I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: (only one box must be initialled)

	Choice NOT To Have my Life Prolonged

I do not want my life to be prolonged if:

- I have an incurable and/or irreversible condition that will result in my death within a relatively short time
- I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or
- the likely risks and burdens of treatment would outweigh the expected benefits

☐ **Choice To Have my Life Prolonged**

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

2. Relief from Pain

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort should be provided at all times even if it hastens my death:

_____
_____
_____
_____

3. Other Wishes

In the event of the individual is not in agreement with any of the optional choices above and wish to write his/her own, or if he/she wishes to add to the instructions given above, these wishes are to be provided below.

I direct that:

_____
_____
_____
_____

4. Primary Care Physician (Optional)

I designate the following physician as my primary physician:

_____
[Name of Physician]

_____
[Address of Physician]

_____
[Telephone Number of Physician]

If the designated physician is not willing, able, or reasonably available to act as primary physician, I designate the following physician as my alternative primary physician:

_____
[Name of Physician]

_____
[Address of Physician]

_____
[Telephone Number of Physician]

5. Donation of Organs at Death (provide a signature in the applicable box)

☐ I give any needed organs, tissue, or body parts

☐ I give the following organs, tissues, or body parts only

_____
_____
_____
_____

☐ My gift is for the following purposes [strike out any of the following that are not intended]

- Transplant
- Therapy
- Research
- Education

I further declare that

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honoured by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

I execute this declaration, as my free and voluntary act

on this _____ day of _____, 20_____

_____
[Place]

_____
[Signature]

This Advance Health Care Directive will not be valid for making health care decisions unless it is either:

- signed by two (2) qualified adult witnesses who are personally known to the individual making the directive and who are present when the directive is signed or acknowledged the signature on the document; or
- acknowledged before a Notary Public or Commissioner of Oaths)

I, a voluntary witness to this Advance Health Care Directive, declare under penalty of perjury under the laws of the Republic of South Africa that:

- the individual who signed or acknowledged this Advance Health Care Directive is personally known to me, or the individual signed or acknowledged this Advance Directive in my presence
- the individual appears to be of sound mind and under no duress, fraud, or undue influence
- I am not a person appointed as agent by this advance health care directive, and
- that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community health care facility, the operator of a community health care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly

I further declare under the laws of penalty of perjury of the Republic of South Africa that I am neither related to the patient by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any portion of the person's estate upon his/her death under a will existing when the Advance Health Care Directive is executed or by operation of law.

Signed at _____

on this _____ day of _____, 20_____

_____
[Name and Address of First Witness]

_____
[Signature of First Witness}

_____
[Name and Address of Second Witness]

_____
[Signature of Second Witness}

On this the _____ day of _____, 20____, I declare: being a Notary Public / Commissioner of Oaths in South Africa, that the person who signed this document in my presence is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to within this document and acknowledged to me that he/she executed the same in his/her authorised capacity, and by placing his/her signature(s) on this document.

WITNESS my hand and official seal.

_____
Signature of Notary / Commissioner of Oaths