MTPD002

# Appointment of medical treatment decision maker (long)

made under the *Medical Treatment Planning and Decisions Act 2016* (Vic.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

Your medical treatment decision maker has legal authority to make medical treatment decisions on your behalf, if you do not have decision-making capacity to make the decision.

**Your medical treatment decision maker is the first person you list below who is reasonably available, and willing and able to make the decision.** Only adults can appoint a medical treatment decision maker.

## Part 1: Personal details

Before you start, read the checklist of steps with this form.

You must fill in your full name, date of birth and address. A phone number is optional.

| | |
|---|---|
| Your full name: | |
| Date of birth: (dd/mm/yyyy) | |
| Address: | |
| Phone number: | |

## Part 2: Medical treatment decision maker details

This form allows you to appoint up to four people.

I **revoke** any other previous appointment of a medical treatment decision maker however described.

I **appoint** as my medical treatment decision maker(s):

**Medical treatment decision maker 1**

Fill in the details of your first medical treatment decision maker here.

| | |
|---|---|
| Full name: | |
| Date of birth: (dd/mm/yyyy) | |
| Address: | |
| Phone number: | |

**Medical treatment decision maker 2**

Fill in the details of your second medical treatment decision maker here.

Cross out this section if you are not appointing a second medical treatment decision maker.

| | |
|---|---|
| Full name: | |
| Date of birth: (dd/mm/yyyy) | |
| Address: | |
| Phone number: | |





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# Appointment of medical treatment decision maker (long) (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

| Appointment by: (insert your full name) | |
|---|---|

**Medical treatment decision maker 3**

Fill in the details of your third medical treatment decision maker here.

Cross out this section if you are not appointing a third medical treatment decision maker.

| Full name: | |
|---|---|
| Date of birth: (dd/mm/yyyy) | |
| Address: | |
| Phone number: | |

**Medical treatment decision maker 4**

Fill in the details of your fourth medical treatment decision maker here.

Cross out this section if you are not appointing a fourth medical treatment decision maker.

| Full name: | |
|---|---|
| Date of birth: (dd/mm/yyyy) | |
| Address: | |
| Phone number: | |

## Part 3: Any limitations or conditions (optional)

Cross out if not including limitations or conditions.

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# Appointment of medical treatment decision maker (long) (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

| Appointment by: (insert your full name) | |
|---|---|

## Part 4: Witnessing

You must sign in front of two adult witnesses.

One witness must be a registered medical practitioner or able to witness affidavits. See justice.vic.gov.au/affidavit for list.

Neither witness can be an appointed medical treatment decision maker for you.

Refer to the checklist if someone else is signing on your behalf.

**Signature of person making this appointment** (you sign here)

Each witness certifies that:

- at the time of signing the document, the person making this appointment appears to have decision-making capacity and appears to understand the nature and consequences of making the appointment and revoking any previous appointment; and
- at the time of signing the document, the person making this appointment appeared to freely and voluntarily sign the document; and
- the person signed the document in my presence and in the presence of a second witness; and
- I am not the person's medical treatment decision maker under this appointment.

**Witness 1 – Authorised witness**

A registered medical practitioner or someone able to witness affidavits must complete this section.

Full name of authorised witness:

Qualification of authorised witness:

Signature of authorised witness: Date: (dd/mm/yyyy)

**Witness 2 – Adult witness**

Another adult witness must complete this section.

Full name of adult witness:

Signature of adult witness: Date: (dd/mm/yyyy)

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For patient record purposes, health services can affix UR number, patient name and date of birth here

| Appointment by: (insert your full name) | |
|---|---|

**If an interpreter is present when this document is witnessed**

If an interpreter is present at the time the document is witnessed, they complete this section immediately after the document is witnessed.

Name of interpreter:

If accredited with the National Accreditation Authority

| NAATI number: | |
|---|---|

I am competent to interpret from English into the following language:

I provided a true and correct interpretation to facilitate the witnessing of the document.

| Signature of interpreter: | Date: (dd/mm/yyyy) |
|---|---|
| | |

## Part 5: Interpreter statement

**If an interpreter assisted in the preparation of this document**

If an interpreter assisted you in preparing this document, the interpreter completes this part.

Cross out Part 5 if not relevant.

I interpreted in the following language:

When I interpreted into this language the person appeared to understand the language used in the document.

Name of interpreter:

| NAATI number (if accredited): | |
|---|---|

| Signature of interpreter: | Date: (dd/mm/yyyy) |
|---|---|
| | |

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# Appointment of medical treatment decision maker (long) (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

| Appointment by: (insert your full name) | |
|---|---|

## Part 6: Statement of acceptance

**Each medical treatment decision maker you appoint must read the statement of acceptance and sign in front of an adult witness.**

Your first medical treatment decision maker must read this statement of acceptance and sign in front of an adult witness.

### Medical treatment decision maker 1

I accept my appointment as medical treatment decision maker and state that:

- I understand the obligations of an appointed medical treatment decision maker; and
- I undertake to act in accordance with any known preferences and values of the person making the appointment; and
- I undertake to promote the personal and social wellbeing of the person making the appointment, having regard to the need to respect the person's individuality; and
- I have read and understand any advance care directive that the person has given before, or at the same time as, this appointment.

Name of medical treatment decision maker:

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| |

Signature of medical treatment decision maker: Date: (dd/mm/yyyy)

| | |
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| | |

Witness completes this section.

I certify that I witnessed the signing of this statement of acceptance.

Name of adult witness:

| |
|---|
| |

Signature of adult witness: Date: (dd/mm/yyyy)

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|---|---|
| | |

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# Appointment of medical treatment decision maker (long) (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

| Appointment by: (insert your full name) | |
|---|---|

## Part 6: Statement of acceptance (cont.)

If you appoint a second medical treatment decision maker, they must read this statement of acceptance and sign in front of an adult witness.

Cross out this section if you are not appointing a second medical treatment decision maker.

**Medical treatment decision maker 2**

I accept my appointment as medical treatment decision maker and state that:

- I understand the obligations of an appointed medical treatment decision maker; and
- I undertake to act in accordance with any known preferences and values of the person making the appointment; and
- I undertake to promote the personal and social wellbeing of the person making the appointment, having regard to the need to respect the person's individuality; and
- I have read and understand any advance care directive that the person has given before, or at the same time as, this appointment.

Name of medical treatment decision maker:

| |
|---|
| |

Signature of medical treatment decision maker: Date: (dd/mm/yyyy)

| | |
|---|---|
| | |

Witness completes this section.

I certify that I witnessed the signing of this statement of acceptance.

Name of adult witness:

| |
|---|
| |

Signature of adult witness: Date: (dd/mm/yyyy)

| | |
|---|---|
| | |

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# Appointment of medical treatment decision maker (long) (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

| Appointment by: (insert your full name) | |
|---|---|

## Part 6: Statement of acceptance (cont.)

**Medical treatment decision maker 3**

If you appoint a third medical treatment decision maker, they must read this statement of acceptance and sign in front of an adult witness.

Cross out this section if you are not appointing a third medical treatment decision maker.

I accept my appointment as medical treatment decision maker and state that:

- I understand the obligations of an appointed medical treatment decision maker; and
- I undertake to act in accordance with any known preferences and values of the person making the appointment; and
- I undertake to promote the personal and social wellbeing of the person making the appointment, having regard to the need to respect the person's individuality; and
- I have read and understand any advance care directive that the person has given before, or at the same time as, this appointment.

Name of medical treatment decision maker:

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| |

Signature of medical treatment decision maker: Date: (dd/mm/yyyy)

| | |
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| | |

Witness completes this section.

I certify that I witnessed the signing of this statement of acceptance.

Name of adult witness:

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|---|
| |

Signature of adult witness: Date: (dd/mm/yyyy)

| | |
|---|---|
| | |

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# Appointment of medical treatment decision maker (long) (cont.)

For patient record purposes, health services can affix UR number, patient name and date of birth here

| Appointment by: (insert your full name) | |
|---|---|

## Part 6: Statement of acceptance (cont.)

If you appoint a fourth medical treatment decision maker, they must read this statement of acceptance and sign in front of an adult witness.

Cross out this section if you are not appointing a fourth medical treatment decision maker.

**Medical treatment decision maker 4**

I accept my appointment as medical treatment decision maker and state that:

- I understand the obligations of an appointed medical treatment decision maker; and
- I undertake to act in accordance with any known preferences and values of the person making the appointment; and
- I undertake to promote the personal and social wellbeing of the person making the appointment, having regard to the need to respect the person's individuality; and
- I have read and understand any advance care directive that the person has given before, or at the same time as, this appointment.

Name of medical treatment decision maker:

| |
|---|
| |

Signature of medical treatment decision maker: Date: (dd/mm/yyyy)

| | |
|---|---|
| | |

Witness completes this section.

I certify that I witnessed the signing of this statement of acceptance.

Name of adult witness:

| |
|---|
| |

Signature of adult witness: Date: (dd/mm/yyyy)

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| | |

You have reached the end of this form.

- Please keep your original 'Appointment of medical treatment decision maker' form safe and accessible for when it is needed.
- It is recommended your medical treatment decision maker has read and understood the contents of your advance care directive (if any).
- Your 'Appointment of medical treatment decision maker' form and advance care directive can be uploaded on MyHealth Record and it is recommended copies be shared with your appointed medical treatment decision maker and relevant health practitioner(s) / health service(s).