



Government of **Western Australia**
 Department of **Health**
End-of-Life Care Program

**For further information about
 Advance Health Directives contact:**

Department of Health
 T: (08) 9222 2300
 E: acp@health.wa.gov.au
 W: healthywa.wa.gov.au/AdvanceCarePlanning

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_____ Mobile: _____
 _____ Tel: _____
 _____ 2. Name: _____
 _____ Mobile: _____
 _____ Tel: _____
 _____ 1. Name: _____

Contact details:
 Have you appointed an enduring guardian? Yes No

Enduring Power of Guardianship

Advance Health Directive

My name is:

First name: _____

Last name: _____

Date of birth: _____

Please print

A L E R T

Advance Health Directive

In case of a medical emergency please contact the person below who will have a copy of my Advance Health Directive (AHD).

My name: _____

Person who will have a copy of my AHD:

First name: _____

Last name: _____

Contact number: _____

Relationship to me: _____

My AHD is located at: _____

My GP is also aware of my AHD and has a copy.

GP name: _____

GP tel: _____

Other people who hold copies of my AHD are:

Name: _____ Tel: _____

Name: _____ Tel: _____

Name: _____ Tel: _____

Usual treating hospital: _____