



## Voluntary assisted dying in Western Australia

# How to fill in a Contact Person Appointment Form

- These instructions will help you understand which parts of the Contact Person Appointment Form need to be completed, and who needs to complete them.
- You must appoint a Contact Person (using this form) if you make a self-administration decision in relation to voluntary assisted dying.
- The [Choosing the Contact Person](#) and [Being the Contact Person](#) information sheets have more information about the role of the Contact Person, including who can be a Contact Person and what they have to do.
- If you need help contact:
  - your Coordinating Practitioner, or
  - the Statewide Care Navigator Service  
Phone: 08 9431 2755  
Email: [VADCareNavigator@health.wa.gov.au](mailto:VADCareNavigator@health.wa.gov.au)

## Part A. Patient information

### Completed by

The patient OR another person on the patient's behalf.

### Instructions

Is part A already filled in?

#### Yes

- Check to make sure information is correct.
- Cross out and rewrite any information that is incorrect.
- Move on to part **B. Coordinating Practitioner** information.

#### No

- Complete the fields highlighted in **yellow**.
- Other fields should also be completed if they are relevant.

A. Patient information	
Unique patient ID (from VAD-IMS)	861791
Title	<input checked="" type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms <input type="checkbox"/> Miss <input type="checkbox"/> Dr <input type="checkbox"/> Other (please specify) <input type="text"/>
Family name	Alan
Given name	Citizen
Other given name(s)	
Date of birth (DD/MM/YYYY)	01/01/1950
Home address (line 1)	Hay Street Mall
Home address (line 2)	
Suburb	Perth
State	WA
Postcode	6000
Is your mailing address different to your home address?	<input checked="" type="checkbox"/> No <input type="checkbox"/> Yes
If yes, please complete the fields below.	
Mailing Address (line 1)	
Mailing Address (line 2)	
Suburb	
State	
Postcode	
Telephone number	08 9555 5555
Email address	

## Part B. Coordinating Practitioner information

### Completed by

If not already filled in by the practitioner, the patient OR another person on the patient's behalf can complete.

### Instructions

Is part B already filled in?

#### Yes

- Check to make sure information is correct.
- Cross out and rewrite any information that is incorrect.
- Then move on to part **C. Patient Declaration**.

#### No

- Complete the fields highlighted in **yellow**.
- Other fields should also be completed if they are relevant.

## Part C. Contact Person information

### Completed by

The patient OR another person on the patient's behalf.

### Instructions

Complete the fields highlighted in **yellow**.

Other fields should also be completed if they are relevant.

## Part D. Communication

### Completed by

The patient OR another person on the patient's behalf.

### Instructions

Was the Contact Person appointed with the assistance of an interpreter?

#### No

- Place a tick in the box next to 'No' and move on to part **E. Statement of the Contact Person**.

#### Yes

- Place a tick in the box next to 'Yes' and complete the **purple** section.

**B. Coordinating Practitioner information**

Unique practitioner ID (from VAD-IMS) 505024

AHPRA Registration Number MED000000001

Title  Mr  Mrs  Ms  Miss  Dr  Other (please specify) \_\_\_\_\_

Family name Smith

Given name Amy

Other given name(s) \_\_\_\_\_

Work address (line 1) 1 St Georges Terrace

Work address (line 2) \_\_\_\_\_

Suburb Perth

State WA Postcode 6000

Is the Coordinating Practitioner's mailing address different to their work address?  No  Yes

If yes, please complete the fields below.

Mailing address (line 1) \_\_\_\_\_

Mailing address (line 2) \_\_\_\_\_

Suburb \_\_\_\_\_

State \_\_\_\_\_ Postcode \_\_\_\_\_

Telephone number 95555555

Email address vadims.bvt+Pract1@gmail.com

**C. Contact Person information**

Title  Mr  Mrs  Ms  Miss  Dr  Other (please specify) \_\_\_\_\_

Family name \_\_\_\_\_

Given name \_\_\_\_\_

Other given name(s) \_\_\_\_\_

Date of birth (DD/MM/YYYY) \_\_\_\_\_

Home address (line 1) \_\_\_\_\_

Home address (line 2) \_\_\_\_\_

Suburb \_\_\_\_\_

State \_\_\_\_\_ Postcode \_\_\_\_\_

Is the Contact Person's mailing address different to their home address?  No  Yes

If yes, please complete the fields below.

Mailing address (line 1) \_\_\_\_\_

Mailing address (line 2) \_\_\_\_\_

Suburb \_\_\_\_\_

State \_\_\_\_\_ Postcode \_\_\_\_\_

Telephone number \_\_\_\_\_

Email address \_\_\_\_\_

**D. Communication**

Did you make the appointment of the Contact Person with the assistance of an interpreter?

No

Yes

If yes, please complete the Interpreter information below.

**Interpreter information (IF APPLICABLE)**

What type of interpreter service was required?

Spoken language other than English

Non-spoken communication (e.g. AUSLAN)

**Note: interpreters must meet all of the criteria below to be an interpreter for this patient under the Act.**

The interpreter has confirmed to me that they:

- are accredited with the National Accreditation Authority for Translators and Interpreters (NAATI);
- are **not** a family member of the patient;
- do **not** know or believe that they are a beneficiary under a will of the patient;
- do **not** know or believe that they may otherwise benefit financially or in any other material way from the death of the patient;
- are **not** an owner, or responsible for management, of a health facility where the patient is being treated or lives; and
- are **not** directly involved in providing health services or professional care services to the patient.

Title  Mr  Mrs  Ms  Miss  Dr  Other (please specify) \_\_\_\_\_

Family name \_\_\_\_\_

Given name \_\_\_\_\_

Other given name(s) \_\_\_\_\_

Telephone number \_\_\_\_\_

Email address \_\_\_\_\_

Accreditation details (Practitioner Number) \_\_\_\_\_

## Part E. Statement of Contact Person

### Completed by

The Contact Person.

### Instructions

Place a tick in **one** of the checkboxes highlighted in yellow (consent or do not consent).

Complete **all** of the other fields.

**E. Statement of Contact Person**

I, \_\_\_\_\_ consent to my appointment as Contact Person for  
Citizen Alan \_\_\_\_\_ Patient Name \_\_\_\_\_

I understand the requirements of my role under the *Voluntary Assisted Dying Act 2019*, including:

- the requirements under section 105 to give the prescribed substance, or any unused or remaining prescribed substance, to an Authorised Disposer, and that penalties apply for non-compliance with these requirements; and
- the requirements under section 67(2) to inform the patient's Coordinating Practitioner if the patient dies, whether as a result of self-administering the prescribed substance or from some other cause.

I consent  
**OR**  
 I do not consent

- to the Voluntary Assisted Dying Board contacting me to advise that the prescribed voluntary assisted dying substance for the patient has been supplied to a person other than me.

Signature \_\_\_\_\_ Date (DD/MM/YYYY) \_\_\_\_\_

## Part F. Consent statement and signature of patient

### Completed by

The patient OR another person on the patient's behalf.

### Instructions

Place a tick in **one** of the checkboxes highlighted in yellow (consent or do not consent).

Complete **all** of the other fields **above** the green section.

Can the patient sign the Form?

### Yes

- Complete the green section.

### No

- Complete the blue section.

**Once all sections are complete, give the Contact Person Appointment Form to your Coordinating Practitioner.**

**F. Consent statement and signature of patient**

I, Citizen Alan \_\_\_\_\_ Patient Name \_\_\_\_\_ have appointed \_\_\_\_\_ Contact Person Name \_\_\_\_\_ as my Contact Person.

I, Citizen Alan \_\_\_\_\_ Patient Name \_\_\_\_\_

consent  
**OR**  
 do not consent

- to the Voluntary Assisted Dying Board informing \_\_\_\_\_ Contact Person Name \_\_\_\_\_ that the prescribed voluntary assisted dying substance has been supplied for me.

Signature of patient \_\_\_\_\_ Date (DD/MM/YYYY) \_\_\_\_\_

**If the patient is unable to sign, the section below applies**

Another person can complete this form on the patient's behalf if:

- the patient is unable to complete this form themselves; and
- the patient has directed the person to complete this form; and
- the person has reached 18 years of age; and
- the person signs the form in the presence of the patient.

Name of person (print name) \_\_\_\_\_

Signature of person \_\_\_\_\_ Date (DD/MM/YYYY) \_\_\_\_\_

(in the presence of the patient)

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