

Life Without Barriers (LWB) wants to make sure you can live your best life and make choices. This Statement of Informed Choice is our way of working with you to see if we can support your choices and meet our responsibilities.

The Statement of Informed Choice should be filled out when you want to use your rights and make a decision that might not follow LWB policy.

All parts of the form related to your choice must be completed, signed and returned to your LWB support staff. When the form is returned, LWB will work with you to find other options that could work for both you and LWB.

If you have any questions about this form. Contact the LWB staff member you feel most comfortable talking with.

<b>Part A: Details:</b>			
<b>Name:</b>		<b>Date:</b>	
<b>Address:</b>		<b>DOB:</b>	
<b>Phone:</b>		<b>Email:</b>	
<b>Decision making</b>	I make my own decisions:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	I have been legally appointed as a decision-maker:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	I use my decision-making support to help me:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Part B: Details of Person Assisting to Complete Form (complete as applicable)</b>			
<b>Name:</b>		<b>Date:</b>	
<b>Relationship to person:</b>		<b>Email:</b>	
<b>Phone:</b>			
<b>Decision Making</b>	I have been legally appointed as a decision-maker.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	I have been nominated as a decision-making support:	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	What help have you given in completing this form:		



When filling out Part C of this form, if your choice sits in areas outlined in **RED** LWB requests that you contact your doctor or health professional or call Healthdirect on 1800 022 222 for advice.

Part C: Specific area related to identified risk

<b>Medication</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify: (for example declining to take seizure medication).
<b>Declining medical support or treatment</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify: (for example regular check-up with GP)
<b>Declining Support with High Intensity Daily Personal Activities (HIDPA)</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify: (for example declining wound care)
<b>Use of illegal substances</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify: (for example cannabis)
<b>Use of legal substances</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify: (for example tobacco/alcohol)
<b>Declining referral to another service</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify: (for example Allied Health OT)
<b>Unsafe Actions or hazards</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify: (for example gambling, criminal activity, wandering)
<b>Environmental &amp; Social</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify: (for example travel/transport, extreme cultural or religious activities)
<b>Other</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please specify:

Part D: LWB has worked with me to:		
Explain the risk and develop a risk assessment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date & detail of discussion:
Tell me how my choice goes against LWB policy.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date & detail of discussion:
Help me look at different ideas and ways to support my choice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date & detail of discussion:
Explain that LWB cannot help me because they think the risk or possible harm is too high.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date & detail of discussion:
Part E: My declaration to exercise my rights and choice:		
I understand the risks and possible harm of my choice.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
I accept the risk of any harm or injuries that may happen to me due to my choice. I will not hold LWB or any of its employees as neglectful or responsible for harm resulting from my choice.	<input type="checkbox"/> Yes <input type="checkbox"/> No	
I request the choices recorded in this document be respected and observed.	<input type="checkbox"/> Yes	
Name	Signature	Date
Person we support:		
Person Assisting:		
LWB Representative:		

LWB will upload a copy of your completed Statement of Informed Choice to your CIRT file.

**Upload to CIRT:** Legal > Consents > Add New Consent > Statement of Informed Choice > SURNAME, First Name. YYYY.MM.DD

Office use only:

Uploaded to CIRTS	Staff Name:	Date Uploaded:	Signed:
Copy of completed form returned to the person	Staff Name:	Date:	Signed: