Has the patient participated in advance care planning? ☐ Yes ☒ No

Provide details:

5. Consenting details

Complete this section, irrespective of the patient's capacity.

Patients with capacity can provide their own consent.
For patients with impaired capacity, consent must be obtained from a substitute decision-maker(s), in the order below.

The patient has:

1. Advance Health Directive (AHD)	☐ Yes	☐ No
2. Tribunal-appointed Guardian (see 5. below)	☐ Yes	☐ No
3. Attorney(s) for health matters under Enduring Power of Attorney or AHD	☐ Yes	☐ No
4. Statutory Health Attorney†	☐ Yes	☐ No

5. If no to all, The Public Guardian can be contacted for consent for further discussions about withholding and/or withdrawing life sustaining measures.
Visit www.publicguardian.qld.gov.au

Name/details of substitute decision-maker(s): (e.g. relationship to patient, phone number, location of original AHD)

Record the dates and times of discussions held w consent obtained from, the patient and/or substitu maker(s). Cross reference with progress notes.

Details of consenting discussions:

Discussed with Dr Carroll during consu round. Explained that Rhonda has mu comorbidities and if she becomes ver would need to make a call on how agg treatments need to be. Rhonda agree would want her ceiling of care to be f based cares with MET calls, and in the renal failure (current admission) woul renal replacement therapy only if app would want further discussion when t comes.

†**A statutory health attorney** is, in the following order: a spous facto and same sex partners) in a continuing relationship, an a the person (not a paid carer), an adult who is a close friend or r carer). *(s. 63 Powers of Attorney Act 1998).*

6. Clinician authorisation

This ARP form remains active:

☐ For this admission/attendance

☐ Until date: (Not longer than 12 months)

☒ For 12 months (expected expiry: 20-Nov-2024)

In all cases, review of an ARP on re-admission/attendance is preferred.

Medical practitioner/health professional completing this form:

Ejuin Woo

(Digitally signed by above health professional)

Date: 21-Nov-2023 06:11:08 PM

Practice/facility name:

Redcliffe Hospital

Role and qualification:

REG Oncology Pall Care Redcliffe

Best contact number:

Authorising senior medical practitioner's name*, if applicable:

Recommendations for review, if circumstance (e.g. will the ARP apply during planned surgery or followin

COP

Other clinicians involved in the development form and/or provided with a copy: (e.g. emerge team, surgical team, palliative care service, GPs, allied he professionals, QAS paramedics).

Transcribed Original Author:

☐

*If required, the authorising medical practitioner will be a more medical practitioner/consultant and must be involved in all deci withdraw medical treatment.

If changes are required, this form must be voided and a new ARP form completed

Sent from my iPhone

Begin forwarded message:

From: Holly Osborne <hollyteganosborne@hotmail.com>
Date: 11 March 2025 at 1:01:40 pm AEST

To: Christie Gardiner <Christie.Gardiner@hallandwilcox.com.au>, Laura Hanrahan <Laura.Hanrahan@hallandwilcox.com.au>
Subject: Fw: EPOA dated 9.03.2025 - Rhonda Ann Knyvett

Hi Christie,
Please find attached new EPOA dated 9.03.2025 for the time being.

_____
From: Holly Osborne
Sent: Tuesday, 11 March 2025 1:00 PM
To: Simon Thompson <Simon@lifelegacylegal.com.au>; Stuart Loudon <Stuart@loudonlegal.com.au>; Tammy Slater <tammys@gillandlane.com.au>; Simon Thompson <Simon@lifelegacylegal.com.au>; Honda.r@hotmail.com <honda.r@hotmail.com>; Michelle Tesch <Michelle@gillandlane.com.au>
Subject: EPOA dated 9.03.2025 - Rhonda Ann Knyvett

Afternoon

Please find attached enduring power of attorney (EPOA) dated 9.03.2025 naming Holly Dahm, and Riki Dahm as EPOA severely for Rhonda Ann Knyvett.
@Honda.r@hotmail.com<mailto:honda.r@hotmail.com> as required, I am notifying you that the EPOA has been enlivened.
A scanned copy will be provided shortly.

Kind regards
Holly

Contact details

Rhonda Ann Knyvett
honda.r@hotmail.com
0413 688 334

Riki Lee Dahm
rikidahm@gmail.com
0421 161 433

Holly Tegan Dahm
hollyteganosborne@hotmail.com
0401219842

<EPOA 9.03.2025.zip>

Hall & Wilcox | Smarter Law Update
Keep up to date and view our Latest Thinking
If our bank account details change, we will notify you by letter, phone call or face-to-face, but never by email.
Hall & Wilcox acknowledges the Traditional Custodians of the land, sea and waters on which we work, live and engage. We pay our respects to Elders past, present and future.
This email and any attachment is confidential and for the use of the intended recipient(s) only. It may also be the subject of legal professional privilege. If you are not the intended recipient, any use, interference with, disclosure or copying of this material is unauthorised and prohibited. Hall & Wilcox handles information according to relevant privacy laws.
Our privacy policy can be reviewed at our website: http://www.hallandwilcox.com.au/privacy/

Subject: Re: EPOA dated 9.03.2025 - Rhonda Ann Knyvett [HW-ACTIVE.FID5037940]
Date: Tuesday, 11 March 2025 at 3:45:23 PM Australian Eastern Standard Time
From: Holly Osborne <hollyteganosborne@hotmail.com>
To: Christie Gardiner <Christie.Gardiner@hallandwilcox.com.au>
CC: Riki Dahm <rikidahm84@gmail.com>, Laura Hanrahan <Laura.Hanrahan@hallandwilcox.com.au>
Category: H & W
Attachments: image001.png, image002.jpg, image003.jpg, image004.jpg, image005.jpg, image006.jpg, image007.jpg, image008.jpg, image009.jpg, image010.jpg, image011.jpg, image012.jpg, image013.jpg, image014.jpg, image015.jpg, image016.jpg, image017.jpg, 18.02.2025 Rhonda Ann Knyvett Medical Certificate.pdf, Rhonda Ann Knyvett - Cardiac Unit, Prince Charles, Hospital Admission for cardia procedure 27 March 2025.jpg, Application for leave to be represted at the tribunal by Stuart Loudon 1.jpg, 5.05.2023 Will - Rhonda Ann Knyvett - Garth Wilfred Osborne & Holly Tegan Dahm - co executitors.pdf

Please find attached the medical certificate, which outlines the impact of Garth on Rhonda, including details of her medical conditions. The certificate confirms that her condition requires medical intervention, specifically a procedure involving her heart and a stent.

Additionally, I have attached statements from Garth discussing Rhonda, including references to self-harm and past substance dependence issues, particularly alcohol. The incident Garth is referring to occurred a short time after Garth drafted Rhonda's dated 5.5.23 Will (ino longer valid, as she had a new one done due to concerns about the wording).These statements demonstrate how he has used this information to his advantage. Also included is information related to his discussions about superannuation withdrawals.

All of this material has been submitted as part of the QCAT proceedings. Some has not yet been served, but the documents have been lodged via the portal—hence the screenshot. The others have been formally served.

Holly

From: Christie Gardiner <Christie.Gardiner@hallandwilcox.com.au>
Sent: Tuesday, 11 March 2025 2:23 PM
To: Holly Osborne <hollyteganosborne@hotmail.com>
Cc: honda.r@hotmail.com <honda.r@hotmail.com>; Riki Dahm <rikidahm84@gmail.com>; Laura Hanrahan <Laura.Hanrahan@hallandwilcox.com.au>
Subject: RE: EPOA dated 9.03.2025 - Rhonda Ann Knyvett [HW-ACTIVE.FID5037940]

Thanks for sending the Advance Health Directive Holly. After speaking with Rhonda, this AHD does not need to be updated. We will prepare the new Enduring Power of Attorney and get that to you for review as soon as we can.

Can you please send through the letter from Rhonda's treating doctor regarding her deteriorated health resulting from the issues with Garth?

Regards

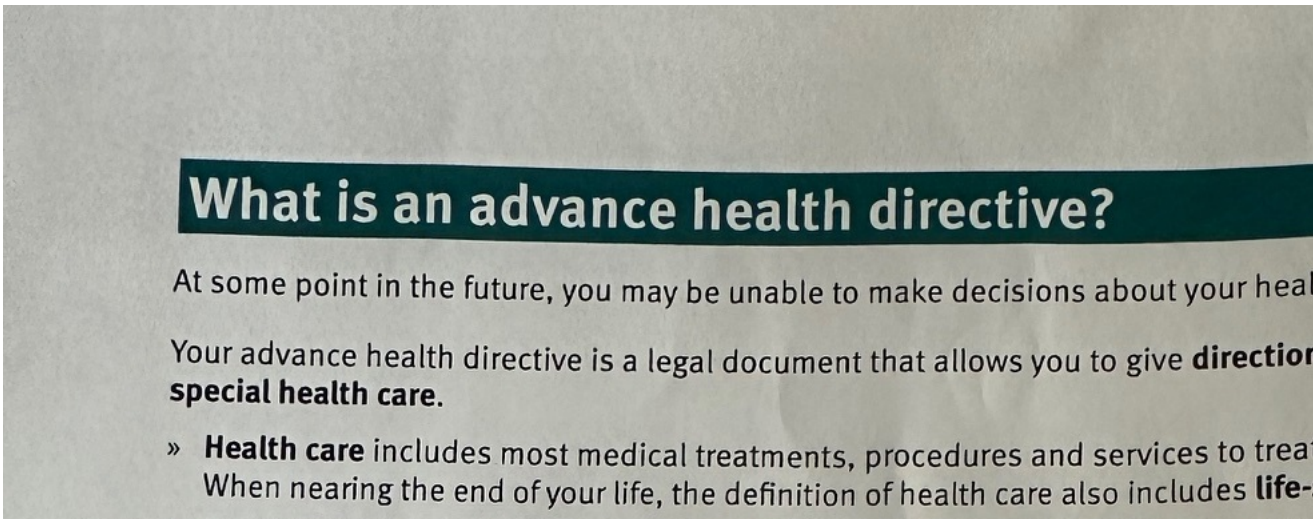
Christie Gardiner | Associate

T +61 7 3231 7798 | F +61 7 3231 7799
Christie.Gardiner@hallandwilcox.com.au

Hall&Wilcox
smarter law

From: Holly Osborne <hollyteganosborne@hotmail.com>
Sent: Tuesday, 11 March 2025 2:08 PM
To: Christie Gardiner <Christie.Gardiner@hallandwilcox.com.au>
Cc: honda.r@hotmail.com; Riki Dahm <rikidahm84@gmail.com>
Subject: Fwd: EPOA dated 9.03.2025 - Rhonda Ann Knyvett

Please find below AHD



» **Special health care** includes special procedures such as participation in specia

Your advance health directive also allows your wishes to be known and gives heal treatment you want.

As the person who is making this advance health directive, you are referred to as t this advance health directive will only **operate if you do not have capacity** to make

Appointing an attorney (decision-maker)

You can also use this form to appoint someone that you trust to make decisions a time **when you do not have capacity to make decisions about your health care**. Th **'attorney'**.

Important information about your advance health directive

» This form can only be completed by an adult who has capacity to make an adva must understand the nature and effect of the document you are signing. You mu voluntarily, not due to pressure from someone else to make it.

» **A doctor must sign section 5 'Doctor certificate' of this form**.

» **You must sign this form in the presence of an eligible witness** (a justice of the declarations, lawyer or notary public).

» If an interpreter is required to interpret or translate this document, they should translator's statement.

» You are not required to register this advance health directive anywhere.

What to do with this advance health directive once complete:

» give a certified copy to your attorney(s) (if appointed), lawyer, doctor or he

» notify your close family and friends that you have made an advance health document.

Form 4

Powers of Attorney Act 1998 (Qld) section 44(2)
Version 5: approved for use from 30 November 2020.

For patient record purposes, health servi

Advance health direc
(Queensland)

Use this form to give directions about your future health ca
health care. You can also use this form to appoint an attor
health matters.

To help you complete this form, please read **Form 10 — Ad
directive explanatory guide** first.

You should then talk to people who are important to you a
inform your healthcare choices including your doctor, fami

Forms and explanatory guides are available at www.qld.gov.au/guardia

SECTION 1: YOUR PERSONAL DETAILS

You must fill in your full name, date of birth and address.

Refer to section 1, page 5 of Form 10 — Advance health directive explanatory guide.

Full name	Rhonda Ann Knyvett
Date of birth	18/10/1957
Address	[redacted]
	Bracken Ridge Suburb Q St
Phone number	0413688334
Email	hond.r@hotmail.com

SECTION 2: YOUR HEALTH CONDITIONS AND CONC

Refer to section 2, page 5 of Form 10 — Advance health directive explanatory guide.

Cross out this section if you do not want to complete it. If you do complete this section cross out any space

My major health conditions and concerns are:

CREST syndrome
Kidney damage post AKI
Cardiac issues
Liver cirrhosis- Hep C from blood transfusion
Breast Cancer- Bilateral mastectomies
Osteoporosis
Hypothyroidism

in the box that you do not use.

Multiple tendon releases and orthopedic procedures
Chronic infection left elbow

SECTION 3: YOUR VIEWS, WISHES AND PREFEREN

This section lets your health provider, family and friends know what is important to you now and into the future.

You are not giving directions about your health care (section 4 allows you to do this). You should discuss this section with your doctor before completing it.

Refer to section 3, pages 5–6 of Form 10 — Advance health directive explanatory guide.

Cross out this section if you do not want to complete it. If you do complete this section cross out any space in the boxes that you do not use.

(a) These things are important to me: (*Describe what liv into the future* e.g. spending time with your family and

The joy of being closer to my family.
To live without pain as much as possible.
To not be in hospital. Living with family.
When I'm well I volunteer and cook.
Reading
Visit family in Koah (North QLD)

(b) These things worry me about my future: (e.g. being unable to live at home, being unable to com

Pain and having no quality of life. Not being able to speak or feed myself.

(c) These are the cultural, religious or spiritual values, rituals or beliefs I would like considered in

(d) When I am nearing death, the following would be important to me and would comfort me: (e.g. at home or you may like a certain type of music played)

At home unless it becomes difficult then be in Palliative care.
Have family with me and have their faces as the last thing I see.
Listen to audio books.

(e) I would prefer these people to be involved in discussions about my health care:

Holly Dahm (daughter/EPOA)
Riki Dahm

(f) I would prefer these people not be involved in discussions about my health care:

SECTION 4: YOUR DIRECTIONS

Before completing section 4, it is recommended that you discuss your proposed directi

DIRECTIONS ABOUT LIFE-SUSTAINING TREATMENT

This part allows you to give **directions about life-sustaining treatment when you are nearing the** directions about health care other than life-sustaining treatments, complete the part 'Directions care' on page 7.

Life-sustaining treatments are aimed at sustaining or prolonging your life (i.e. keeping you aliv death). Examples could include CPR (cardiopulmonary resuscitation) and assisted ventilation (e of a breathing machine).

Your directions about life-sustaining treatment that you provide below will only apply if you are capacity to make your own decisions about health care and one of the following applies:

- you are so unwell due to a terminal illness or condition that, in the opinion of two doctors, yo to die in the next 12 months
- you are so unwell due to an injury or illness that there is no reasonable prospect that you will that you can live without life-sustaining treatment
- you are permanently unconscious (with no reasonable prospect of regaining consciousness)
- you are in a persistent vegetative state (involving severe and irreversible brain damage).

A health provider does not have to follow directions in an advance health directive that are not medical practice or will not benefit you. A health provider also does not have to follow direction where circumstances, including advances in medicine, have changed to the point that your dire appropriate. **Before completing this section, it is recommended that you discuss your propose your doctor.**

You can only choose one option.

Read all four options (see next page for option 4) before you make a decision.

Refer to section 4, pages 7–8 of Form 10 — Advance health directive explanatory guide.

I give the following directions about life-sustaining treatment:

*(Please choose **only one** of the following four options)*

Option 1

☐ **I consent to all** treatments aimed at sustaining or prolongin

OR

Option 2

☑ **I refuse** any treatments aimed at sustaining or prolonging n

OR

Option 3

☐ **I cannot decide at this point.** I want my attorney(s) to make sustaining treatment on my behalf at the time the decision the information in this advance health directive and in con providers and the people I have listed in section 3.

OR

See next page for option 4.

DIRECTIONS ABOUT BLOOD TRANSFUSIONS

A blood transfusion is the transfer of blood, including blood products (e.g. red cells, platelets and plasma) from one person to another.

Refer to section 4, page 9 of Form 10 — Advance health directive explanatory guide.

I give the following direction about blood transfusions:

(Tick one box only)

☑ I **consent** to a blood transfusion

OR

☐ I **do not** consent to a blood transfusion

OR

☐ **other:**

(If you tick this box you must specify the circumstances or t
consent to or refuse, e.g. I consent to a transfusion of bloo

SECTION 5: DOCTOR CERTIFICATE

A doctor must complete, sign and date this section.

INFORMATION FOR THE DOCTOR

Refer to section 5, pages 9–10 of Form 10 — Advance health directive explanatory guide and the *Queensland Capacity Assessment Guidelines 2020*.

By signing below, I certify that:

- I am a doctor.
- I have discussed the contents of this advance health direct
- At the time of making this advance health directive the prin the capacity to make this advance health directive. The prir
  - understand the nature and effect of this advance health
  - be capable of making this advance health directive free
- I am not:
  - the person witnessing this advance health directive
  - the person signing this advance health directive for the
  - an attorney of the principal
  - a relation of the principal or relation of an attorney of th
  - a beneficiary under the principal's will.

Doctor's name	

DR.

Name of facility or practice	Dr. Shaheed Moideen smar Prov. No. 281627HL SmartClinics Taigum
Address of facility or practice	1/217 Beams Rd Taigum Qld 4018 Ph: (07) 3205 4555
	Suburb / State
Phone number	
Doctor's signature:	

Option 4

☐ **I give the following specific directions** about life-sustaining trea

(Tick one box per row in the table below)

Life-sustaining treatment	(a) I consent to this treatment in all circumstances	(b) I refuse this treatment in all circumstances	(c) I consent to this trea circumstances *(You m circumstances for each trea*
CPR (cardiopulmonary resuscitation) *(For option (c), specify circumstances here)*	☐	☐	
Assisted ventilation (e.g. a machine which assists your breathing through a face mask or a breathing tube) *(For option (c), specify circumstances here)*	☐	☐	

Artificial nutrition
(e.g. a feeding tube through the nose or stomach)
(For option (c), specify circumstances here)

Artificial hydration
(e.g. intravenous (IV) fluids)
(For option (c), specify circumstances here)

Antibiotics
(For option (c), specify circumstances here)

Other life-sustaining treatment
(*state the treatment*, e.g. kidney dialysis)
(For option (c), specify circumstances here)

☐ I need more space.

Attach any additional pages to this form and tick the box to indicate that extra pages are attached.

DIRECTIONS ABOUT OTHER HEALTH CARE

This part allows you to give directions about health care, other than life-sustaining treatment.

You can use this part to give directions to consent to or refuse health care.

I give the following directions about my health care:

Health condition (if relevant)	Directions about my health care
Multiple co-morbidities	I do not want CPR or intubation and v life under any circumstances.

You do not need to specify a health condition but your directions need to be clear.

Refer to section 4, page 9 of Form 10 — Advance health directive explanatory guide.

Kidney failure	I would only want renal dialysis if con the benefit outweighs the burden on r

☐ I need more space.

Attach any additional pages to this form and tick the box to indicate that extra pages are attached.

SECTION 6: APPOINTING AN ATTORNEY(S) FOR HE

This section allows you to appoint one or more attorneys to make decisions about health c
your attorney(s) can make decisions (e.g. jointly, severally, by a majority, successively or al
terms on your attorney(s)' decision-making power or provide instructions on how your atto

WHO ARE YOU APPOINTING AS YOUR ATTORNEY(S) FOR HE

Your attorney(s) must:

- have capacity to make decisions for the matter they are being appointed for
- be 18 years or older
- not be a service provider for a residential service if you are a resident there
- not be your paid carer in the previous three years or your health provider.

Note: a paid carer is someone who is paid a fee or wage to care for a person but not someone receiving a carer's pension or benefit.

Your attorney(s) cannot make decisions that are inconsistent with your directions in section 4 if those directions are clear and can be followed by your health providers.

Refer to section 6, pages 10–11 of Form 10 — Advance health directive explanatory guide.

Cross out this part if you do not want to complete it.

**If you do not want to appoint an attorney(s) for health ma
appointed one in an enduring power of attorney and you c
section 7.**

I appoint the person(s) listed below as my attorney(s) for
(in no particular order)

Full name		
Address		
	Suburb	State
Phone number		
Email		

Full name		
Address		
	Suburb	State
Phone number		
Email		

Full name		
Address		
	Suburb	State
Phone number		
Email		

Full name	

Address		
	Suburb	State
Phone number		
Email		

☐ I am appointing an additional attorney(s) and need mor

Attach any additional pages to this form and tick the box to indicate that ext

HOW MUST YOUR ATTORNEYS MAKE DECISIONS?

Only complete this part if you are appointing more than one attorney.

Refer to section 6, pages 12–13 of Form 10 — Advance health directive explanatory guide.

If you do not complete this part your attorneys must make decisio

I authorise my attorneys to make decisions:

(Tick one box only)

☐ jointly (all of my attorneys must agree on all decisions)

OR

☐ severally (any one of my attorneys may decide)

OR

☐ by a majority (more than half of my attorneys must agree on a

OR

☐ other: (e.g. jointly and severally, or appointing a successive o
(If you choose 'other', please specify how you want your attorn

TERMS AND INSTRUCTIONS FOR YOUR ATTORNEY(S)

Only complete this part if you want to set

Write the terms and instructions for your attorney(s) here:

terms on the exercise of power by your attorney(s) or provide instructions to your attorney(s) about the exercise of their powers.

Refer to section 6, page 13 of Form 10 — Advance health directive explanatory guide.

Cross out this part if you do not want to complete it. If you do complete this part cross out any space in the box that you do not use.

☐ I need more space to write my terms and instructions.

Attach any additional pages to this form and tick the box to indicate th

SECTION 7: DECLARATIONS AND SIGNATURES

PRINCIPAL'S SIGNATURE

As the principal you must sign this part in front of an eligible witness.

Refer to section 7, pages 14–15 of Form 10 — Advance health directive explanatory guide and the *Queensland Capacity Assessment Guidelines 2020*.

An eligible witness **must**

By signing this document, I confirm that:

» I am making this advance health directive freely and voluntarily.

AND

» I understand the nature and effect of this advance health directive

» the nature and likely effects of each direction in this advance h

» that a direction operates only while I do not have capacity for t covered by the direction

» that I may revoke a direction at any time I have the capacity to the health matter covered by the direction

that at any time I do not have capacity to revoke a direction, I w

be a:

- justice of the peace (JP)
- commissioner for declarations
- lawyer
- notary public.

The witness **must not** be:

- the person signing for you
- your attorney (e.g. under an advance health directive or enduring power of attorney)
- someone related to you or related to your attorney
- a paid carer or health provider for you (i.e. your health provider)
- a beneficiary under your will.

» that at any time I do not have capacity to revoke [illegible] effectively oversee the implementation of the direction.

AND

» I understand that if I am appointing an attorney(s) for health matt

- » I may specify or limit my attorney(s)' power and instruct my att exercise of the power
- » the power given to my attorney(s) begins when I lose capacity health matters
- » once my attorney(s)' power begins, my attorney(s) will have fu power to make decisions about, health matters subject to any included in this advance health directive
- » I may revoke the power given to my attorney(s) in this advance time I am capable of making an advance health directive givin
- » the power I am giving to my attorney(s) continues even if I do make decisions about health matters
- » if I am not capable of revoking this advance health directive, oversee the use of the power given to my attorney(s) for healt

ONLY SIGN THIS PART IN FRONT OF AN ELIGIBLE WITNESS

Principal's signature: _____

Witness's signature: _____

(Witness must also sign page 12)

Person signing for the principal

If you are physically unable to sign this form another person who is eligible must sign the form for you.

Refer to section 7, page 15 of Form 10 – Advance health directive explanatory guide.

By signing this document, I confirm that:

- » the principal instructed me to sign this document
- » I am 18 years or older
- » I am not a witness for th health directive
- » I am not an attorney of

Name			
Address			
Suburb		State	Postcod

ONLY SIGN THIS PART IN FRONT OF THE PRINCIPAL AND AN E

Person signing for the principal signs here: _____

Witness's signature: _____

WITNESS CERTIFICATE

This part must be

By signing this document, I certify that: *(Tick one box only)*

[illegible] directive in my presence

filled in and signed by the eligible witness at the same time that you sign the advance health directive.

INFORMATION FOR THE WITNESS

As a witness you are not simply witnessing the principal's signature.

You must also be satisfied that the principal appears to have capacity to make the advance health directive.

Refer to section 7, page 16 and pages 20–21 of Form 10 — Advance health directive explanatory guide and the *Queensland Capacity Assessment Guidelines 2020*.

If an interpreter assisted in the preparation of this document or if an interpreter is present when this document is witnessed, complete Form 7 – Interpreter's/translator's statement at www.publications.qld.gov.au

☒ the principal signed this advance health directive in my p

OR

☐ in my presence, the principal instructed another person to sign this directive for the principal, and that person signed it in my presence of the principal.

AND

» I am a: *(Tick one box only)*

☒ justice of the peace (JP)

☐ commissioner for declarations

☐ lawyer

☐ notary public.

» I am not:

- » the person signing the document for the principal
- » an attorney of the principal
- » a relation of the principal or relation of an attorney of the princip
- » a paid carer or health provider of the principal
- » a beneficiary under the principal's will.

» I have verified that section 5 of this advance health directive has be and dated by a doctor.

» At the time of making this advance health directive the principal ap the capacity to make this advance health directive. The principal ap

- » understand the nature and effect of this advance health directive
- » be capable of making the advance health directive freely and volu

This document (including any additional pages) has 14 pages.

Witness's signature: _____

(Witness must also sign page 11)

Witness's name: Ross Michael Dwyer

JUSTICE OF THE PEACE
QUEENSLAND GOVERNMENT
Reg.No. 304
DEPT. OF JUSTICE & ATTO

SECTION 8: ATTORNEY(S)' ACCEPTANCE

If you have appointed an attorney(s) under section 6 the attorney(s) must sign this section.

It does not matter which order your attorney(s) sign this section.

Your attorney(s) must sign this section of the original form after you and the witness have signed section 7.

INFORMATION FOR ATTORNEYS

An attorney has important duties and obligations.

Refer to section 8, page 17 and pages 22–24 of Form 10 — Advance health directive explanatory guide for further information about the duties and obligations of an attorney.

Note: a paid carer is someone who is paid a fee or wage to care for a person but not someone receiving a carer's pension or benefit.

In signing this advance health directive I accept the appointment in accorda terms of this advance health directive and confirm that:

» I have **read** this advance health directive and I understand that I **must** ma and exercise power in accordance with this advance health directive, the *Attorney Act 1998* and the *Guardianship and Administration Act 2000*.

» I **understand:**

  » in exercising my powers I must apply the general principles and if I ex health care matters, the health care principles under the *Powers of At* and the *Guardianship and Administration Act 2000*

  » the obligations of an attorney and the consequences of failing to com obligations.

» I **declare** that:

  » I have capacity for the matter that I am appointed for

  » I am 18 years or older

  » I am not a paid carer for the principal

  » I am not a health provider for the principal

  » I am not a service provider for a residential service where the princip

Signature: _____

Full name: _____ D

Signature: _____

Full name: _____ D

Signature: _____

Full name: _____ D

Signature: _____

Full name: _____ D

☐ I have appointed an additional attorney(s) and need more space for my

Attach any additional pages to this form and tick the box to indicate extra pa

SECTION 9: WHAT TO DO WITH YOUR COMPLETED A HEALTH DIRECTIVE

You should:

» keep the original in a safe place

» give a certified copy to your attorney(s) (if appointed), doctor, other health provider(s), ban

» notify your close family and friends that you have made an advance health directive and wh

» review your advance health directive at least every two years or if your health changes signi

Refer to 'Further information' on pages 18–19 of Form 10 — Advance health directive explanat on how to make a certified copy and how your advance health directive may be revoked.

My Health Record

If you wish your document to be in My Health Record you can upload it via the My Health Rec www.myhealthrecord.gov.au. Your document will be valid regardless of whether it is upload

Office of Advance Care Planning

You are able to have your advance health directive uploaded to your Queensland Health ele send a copy of your document to the Office of Advance Care Planning. This way it will be eas clinicians involved in your care when it is required. A copy of your document can be sent to t Planning at acp@health.qld.gov.au, PO Box 2274, Runcorn, Queensland 4113 or fax 1300 00

What about registering as an organ donor?

If you are interested in donating your organs **after death**, visit the Australian Organ Donor Re

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Queensland Government

Acute Resuscitation Plan (ARP)

For adults at risk of acute deterioration

Facility: Redcliffe Hospital

URN: RDH 792758 0413688334

Family name: Knyvett

Given name(s): Rhonda

Address: [redacted]

Date of birth: 18-Oct-1957 Sex:

Clinical assessment and appropriate treatment options should be guided by good me which includes discussions with the patient and/or their substitute decision-maker(s)

- This ARP form has been developed as a clinical support tool for use in 'public sector health services' and 'public s facilities' as defined by Hospital and Health Boards Act 2011 (Qld). This ARP form includes references to legal cor indemnities, procedures and conditions of use which may apply only to usage in 'public sector health services' an facilities'. For usage in other services and facilities, these considerations may not apply and/or other considerations independent legal advice or other professional advice is recommended. **While usage of the ARP form by other is authorised by Queensland Health, it is the responsibility of medical practitioners and other health profe this ARP form or using a completed ARP form, without limitation, to independently and adequately satisfy all relevant matters to the standards applicable at law.** To the fullest extent permissible by law, Queensland H warranties, representations and liability in relation to the use of this ARP form.

- **The Quick Guide attached to this form contains important information and should be read prior to comple**
- If there is insufficient room on this form to record information, please cross-reference with the progress notes.

1. Clinical assessment

Record details/assessment of relevant medical conditions relating to the patient's physical and men
This section may include clinical reasons why resuscitation planning is necessary.

Lier cirrhosis secondary to hepatitis C and EtOH, previous breast cancer with bilater
CREST syndrome, recurrrent GIT bleeding from CABE, osteoporosis

2. Capacity assessment

☒ I believe that the patient **has capacity*** to consent to and/or refuse medical treatment.

☐ I believe that the patient **does not have capacity** to consent to and/or refuse medical treatment.

If there is a change in capacity, this form must be reviewed.

Details of assessment:

*A patient with capacity can understand information about their medical treatment and treatment options, weigh up the benefits, risks and bu
and voluntarily make and communicate a decision. Refer to QH Withholding and withdrawing life-sustaining measures clinical guidelines for

3. Resuscitation management plan

If an acute deterioration or critical event occurs, it is clinically indicated to:

Provide e.g. ventilation, IV fluids, supportive therapies.

Intravenous antibiotics (IV AB), Intravenous fluids (IVF), MET Calls/Code Blue/RRT/
Dialysis only if appropriate with discussion

Not provide e.g. defibrillation, intubation, antibiotics.

Defibrillation, Cardiopulmonary resuscitation (CPR), Intubation / Ventilation, Inten
admission / Transfer to ICU/HDU

There is further documentation in the progress notes on the following dates: 21/11/2023

If a cardiac or respiratory arrest occurs, it is clinically appropriate to:

CPR ☐ **Provide** ☒ **Do not pro**

A decision not to provide CPR does not limit other treatn

**Acting on the Resuscitation management plan: if this section differs from section 4 (Patient choic
appropriate dispute resolution process (see Quick Guide). If the dispute remains unresolved, or th
incomplete or unclear when a resuscitation decision is required, attending clinicians should exerc
judgement based on the circumstances, and document this.**

DO NOT WRITE IN THIS BINDING MARGIN

v6.00 - 11/2019

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4. Patient choices

The patient has the following views and wishes about their end-of-life care: (e.g. CPR, pain management option visiting arrangements, spiritual and/or cultural support). Discuss the views and wishes of patients who have impaired their substitute decision-maker(s). Record the dates and times of discussions.

Has the patient participated in advance care planning? ☐ Yes ☒ No

Provide details:

5. Consenting details

Complete this section, irrespective of the patient's capacity.

Patients with capacity can provide their own consent.
For patients with impaired capacity, consent must be obtained from a substitute decision-maker(s), in the order below.

The patient has:

1. Advance Health Directive (AHD)	☐ Yes	☐ No
2. Tribunal-appointed Guardian (see 5. below)	☐ Yes	☐ No
3. Attorney(s) for health matters under Enduring Power of Attorney or AHD	☐ Yes	☐ No
4. Statutory Health Attorney†	☐ Yes	☐ No

5. If no to all, The Public Guardian can be contacted for consent for further discussions about withholding and/or withdrawing life sustaining measures.
Visit www.publicguardian.qld.gov.au

Name/details of substitute decision-maker(s): (e.g. relationship to patient, phone number, location of original AHD)

Record the dates and times of discussions held w consent obtained from, the patient and/or substitu maker(s). Cross reference with progress notes.

Details of consenting discussions:

Discussed with Dr Carroll during consu round. Explained that Rhonda has mu comorbidities and if she becomes ver would need to make a call on how agg treatments need to be. Rhonda agree would want her ceiling of care to be f based cares with MET calls, and in the renal failure (current admission) woul renal replacement therapy only if app would want further discussion when t comes.

†**A statutory health attorney** is, in the following order: a spous facto and same sex partners) in a continuing relationship, an a the person (not a paid carer), an adult who is a close friend or carer). *(s. 63 Powers of Attorney Act 1998).*

6. Clinician authorisation

This ARP form remains active:

☐ For this admission/attendance

☐ Until date: (Not longer than 12 months)

☒ For 12 months (expected expiry: 20-Nov-2024)

In all cases, review of an ARP on re-admission/attendance is preferred.

Medical practitioner/health professional completing this form:

Ejuin Woo

(Digitally signed by above health professional)

Date: 21-Nov-2023 06:11:08 PM

Practice/facility name:

Redcliffe Hospital

Role and qualification:

REG Oncology Pall Care Redcliffe

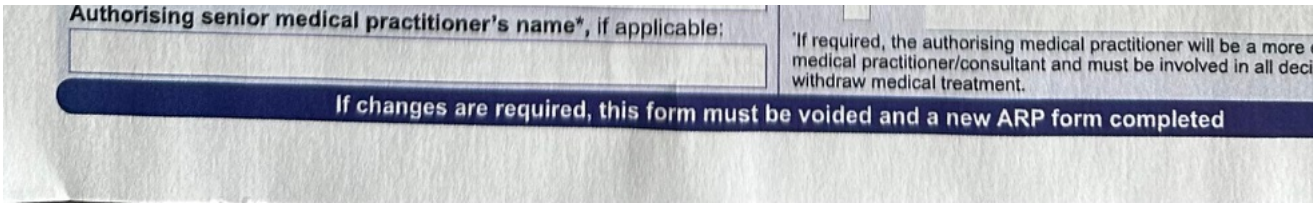
Best contact number:

Recommendations for review, if circumstance (e.g. will the ARP apply during planned surgery or followin

COP

Other clinicians involved in the development form and/or provided with a copy: (e.g. emerge team, surgical team, palliative care service, GPs, allied he professionals, QAS paramedics).

Transcribed Original Author:



Sent from my iPhone

Begin forwarded message:

From: Holly Osborne <hollyteganosborne@hotmail.com>
Date: 11 March 2025 at 1:01:40 pm AEST
To: Christie Gardiner <Christie.Gardiner@hallandwilcox.com.au>, Laura Hanrahan <Laura.Hanrahan@hallandwilcox.com.au>
Subject: Fw: EPOA dated 9.03.2025 - Rhonda Ann Knyvett

Hi Christie,
Please find attached new EPOA dated 9.03.2025 for the time being.

_____
From: Holly Osborne
Sent: Tuesday, 11 March 2025 1:00 PM
To: Simon Thompson <Simon@lifelegacylegal.com.au>; Stuart Loudon <Stuart@loudonlegal.com.au>; Tammy Slater <tammys@gillandlane.com.au>; Simon Thompson <Simon@lifelegacylegal.com.au>; Honda.r@hotmail.com <honda.r@hotmail.com>; Michelle Tesch <Michelle@gillandlane.com.au>
Subject: EPOA dated 9.03.2025 - Rhonda Ann Knyvett

Afternoon

Please find attached enduring power of attorney (EPOA) dated 9.03.2025 naming Holly Dahm, and Riki Dahm as EPOA severely for Rhonda Ann Knyvett.
@Honda.r@hotmail.com<mailto:honda.r@hotmail.com> as required, I am notifying you that the EPOA has been enlivened.
A scanned copy will be provided shortly.

Kind regards
Holly

Contact details

Rhonda Ann Knyvett
honda.r@hotmail.com
0413 688 334

Riki Lee Dahm
rikidahm@gmail.com
0421 161 433

Holly Tegan Dahm
hollyteganosborne@hotmail.com
0401219842

<EPOA 9.03.2025.zip>

Hall & Wilcox | Smarter Law Update
Keep up to date and view our Latest Thinking
If our bank account details change, we will notify you by letter, phone call or face-to-face, but never by email.
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