ADVANCE DIRECTIVE

WHAT IS IT?

An advance healthcare directive is a legal document that allows individuals to specify healthcare preferences and instructions for medical treatment in the event that they are unable to communicate their wishes. An advance directive typically come into effect when a person is no longer able to make decisions due to illness, injury, or trouble thinking.

WHY DO YOU NEED ONE?

Control and Choice: An advance directive allows you to maintain control over your medical treatment decisions, even if you are unable to communicate your wishes. This ensures your preferences for medical care are respected.

Clear and Consistent: An advance directive lays out exactly what you want or don't want regarding medical treatment. This helps to avoid confusion or disagreements among loved ones during difficult times.

Relieves Stress: An advance directive relieves loved ones of the burden of making difficult decisions on your behalf. Outlining your wishes can ease guilt or anxiety associated with having to guess what you may have wanted.

Peace of Mind: You can relax knowing your wishes will be followed, even if you can't express them yourself.

Legal Protection: An advance directive serves as a legal document that protects you from unwanted medical treatment. It acts as evidence of your preferences and can prevent disputes or legal challenges regarding medical decision-making.

Quality of Life: An advance directive helps ensure your medical care matches your beliefs and values, including decisions about end-of-life care, resuscitation, and pain management.

WHAT SHOULD YOU DO WITH IT?

Tell Your Doctors: Let your healthcare providers know you have an advance directive.

Keep Copies Handy: Keep a copy where people can find it easily.

Share with Loved Ones: Tell your closest family and friends what's in the document.

Give a Copy to Your Healthcare Team: If you've named someone to make decisions for you, make sure they have a copy.

ADVANCE DIRECTIVE

Instructions: Parts 1 and 2 may be used together or independently.
Please mark out or void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

PART 1 :

Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my provider must follow my instructions below:

Name: _____ Relation to Patient: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Other Phone: _____

Address:_____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation to Patient: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Other Phone: _____

Address:_____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one):

☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.

☐ I do not give such permission (this form applies only when I no longer have capacity).

(Continued on next page)

PART 2 :

Indicate Your Wishes for Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from a coma.
☐ Yes ☐ No	**Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ Yes ☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes ☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

PART 3 : Other instructions, such as hospice care, burial arrangements, etc.: _____

_____

_____

_____

(Attach additional pages if necessary)

PART 4 : Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

☐ Any organ/tissue

☐ My entire body

☐ Only the following organs/tissues: _____

☐ No organ/tissue donation

Signature:

PART 5 : Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature (Patient): _____ Date: _____

BLOCK A : Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of Witness 1

_____
Signature of Witness 2

BLOCK B : You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

Signature of Notary Public: _____ My commission expires: _____

State: _____ County: _____

WHAT TO DO WITH THIS ADVANCE DIRECTIVE: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; (4) provide a copy to the person(s) you named as your health care agent.

** This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.*