My Choices Advance Directives

Advance Directive for: _____

Address: _____

Date of Birth: _____Telephone: _____

This document has significant medical, legal and possible ethical implications and effects. Before you sign this document, you should become completely familiar with these implications and effects. The operation, effects and implications of this document may be discussed with a physician, a lawyer and/or a clergyman of your choice.

Please fill out SECTION I and/or SECTION II. SECTION III is required for this document to be valid.

SECTION I: Durable Power of Attorney for Health Care. If you choose to leave this section blank, health professionals will attempt to contact your closest relatives if you should be unable to speak or make decisions for yourself. If your relatives are not reasonably available, a qualified substitute decision-maker may be allowed to make decisions for you.

I DO ☐ I DO NOT ☐ want to designate another person as my health care agent to make medical treatment decisions for me if I should become incapacitated or unable to speak for myself.

The person I choose as my health care agent is:

Name: _____

Day phone: _____

Evening phone: _____

Street address: _____

City, State/Zip: _____

My second choice is:

Name: _____

Day phone: _____

Evening phone: _____

Street address: _____

City, State/Zip: _____

SECTION II: Instructions for Health Care (Living Will). If you choose to leave this section blank, health professionals will attempt to contact your closest relatives if you should be unable to speak or make decisions for yourself. If your relatives are not reasonably available, a qualified substitute decision-maker may be allowed to make decisions for you.

I, _____, ask that my family, my doctors and other health care providers, respect my choices as I have communicated them to my health care agent or as I have indicated below. I understand that this document will be referred to only when I am unable to make decisions or speak for myself and when I have an incurable and irreversible condition that will result in death within a relatively short time, or if I become unconscious and to a reasonable degree of medical certainty, will not regain consciousness, or the risks and burdens of treatment would outweigh the expected benefits.

END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have initialed below:

☐ **(a) Choice Not to Prolong Life**

I do not want my life to be prolonged if (i) I have an incurable and irreversable condition that will result in my death within a relatively short time, (ii) I become unconsious and, to a reasonable degree of medical certainty, I will not regain consiosness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, OR

☐ **(b) Choice to Prolong Life**

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

In addition, if I am in the condition described above, I feel especially strongly about the following forms of treatment.

1) I DO ☐ DO NOT ☐ want cardiopulmonary resuscitation.
2) I DO ☐ DO NOT ☐ want artificial ventilation.
3) I DO ☐ DO NOT ☐ want blood or blood products.
4) I DO ☐ DO NOT ☐ want dialysis.
5) I DO ☐ DO NOT ☐ want antibiotics.
6) I DO ☐ DO NOT ☐ want any form of surgery or invasive diagnostic tests.
7) I DO ☐ DO NOT ☐ want a feeding tube.

I realize if I do not specifically indicate my preference regarding any forms of treatment listed above, I may receive that form of treatment.

(complete other side)

SECTION III: Signatures of Declarant and Witnesses.

I am thinking clearly, I agree with everything that is written in this document and I have made this document willingly. If any part of this form cannot be legally followed, I ask that all other parts be followed according to the laws of the state. I also revoke any previous health care directives I have made before.

My signature: _____ Date _____

My name: _____ Date _____

If I cannot sign my name, I can ask someone to sign for me.

Signature of the person who I asked to sign this document for me.

_____ Date _____

Print the name of the person who I asked to sign this document for me.

_____ Date _____

Statement of Witnesses

I personally know the person who signed this document. I believe him or her to be of sound mind and at least 18 years of age. I personally witnessed him or her sign this document, and I believe that he or she did so voluntarily.

By signing as a witness I certify that I am:

- at least 18 years of age;
- not a health care agent appointed by the person signing this document;
- not related to the person signing this document;
- not directly financially responsible for that person's health care;
- not a health care provider directly serving the person at this time;
- not an employee of the health care provider directly serving the person at this time; and
- not aware that I am entitled to or have a claim against the person's estate.

Note: A witness may be a hospital volunteer.

Witness 1: _____ Witness 2: _____

_____ _____
Signature Signature

_____ _____
Date Date

Optional Attachments: Initial if you have included any of these forms with this document.

☐ What I Want my Health Care Agent to Know
☐ What I Want my Family to Know

My Choices Attachment 1:

What I Want My Health Care Agent to Know

Attachment 1: Advance Directive for _____.
Dated _____

Initial statements you agree with.

I understand that my health care agent can make health care decisions for me. I want my agent to be able to do the following:

General Authority of the Health Care Agent

____ Make choices for me about my medical care or services, like tests, medicine or surgery. This care or service can be to find out what my health problem is or how to treat it. It can also include care to keep me alive. If the treatment or care has already started, my health care agent can keep it going or have it stopped.

____ Interpret any instructions I have given in this form or given in other discussion, according to my health care agent's understanding of my choices and values.

____ Review and release my medical records and personal files as needed for my medical care.

____ Move me to another state if needed.

____ Determine which health professionals and organizations provide my medical treatment. My agent may arrange for admission to a hospital, hospice or nursing home for me. My agent can hire any kind of health care worker I may need to help me or to take care of me. My agent can also fire a health care worker if needed.

Specific Health Care Decisions

Life-Sustaining Treatment

____ If I reach a point where it is reasonably certain that I will not recover my ability to interact meaningfully with my family, friends, and environment, I want to stop or withhold all treatments that might be used to prolong my existence.

Treatments I would <u>not</u> want if I were to reach this point include:

____ Tube feedings
____ Artificial ventilation
____ Cardiopulmonary Resuscitation (CPR)
____ Antibiotics
____ Major surgery
____ Blood or blood products

I would <u>not</u> choose to be kept alive with life-sustaining treatments if:

____ I am likely to die in a short period of time and life support would only delay the moment of my death.
____ I am in a coma and not expected to recover.
____ I have permanent and severe brain damage and am not expected to recover.

(complete other side)

Listed here are any other conditions under which I would not wish to be kept alive.

_____

_____

_____

_____

Pain and Symptom Control

☐ If I reach a point where efforts to prolong my life are stopped, I want medical treatments and nursing care that will make me comfortable, even if it increases the risks of my dying sooner.

End-of-Life Care

If there is a opportunity to choose, I would prefer to receive my final care:

☐ at home,
☐ in a hospital,
☐ in an extended care facility, or
☐ in a hospice.

Organ Donation

In the event of my death I wish my agent and caregivers to know:

☐ I *wish to donate only the following* organs or tissues if possible (name the specific organs or tissue)_____

☐ I *wish to donate any* organs or tissues if I am a candidate.

☐ I *do not wish to donate any* organs or tissues.

I also want my health care agent and caregivers to know the following: _____

_____

_____

_____

_____

My Choices Attachment 2:

What I Want My Family and Loved Ones to Know

Attachment 2: Advance Directives for _____.
Dated _____

Please initial the statements you agree with.

The people I consider to be my closest family members are:

_____
_____
_____
_____

This is how I want to be treated if I am near death and cannot speak for myself:

☐ I would like to have members of my church or synagogue notified that I am sick and ask them to pray for me.
☐ I would like to have a cool cloth put on my head if I have a fever.
☐ I would like to be kept clean, have warm baths as often as I can and clean linens at all times.
☐ I would like to have my hand held.
☐ I would like to have my favorite music played. *Suggestions:*_____
☐ I would like pictures of my loved ones near my bed.
☐ I would like to have my personal care such as shaving, nails, hair and teeth attended to as long as it does not cause me pain.
☐ I would like to have people with me.
☐ If I show signs of depression, nausea, shortness of breath or hallucinations, I want my caregivers to do what they can to help me.
☐ I would like people to pray for me.
☐ I would like to be cared for with kindness and cheerfulness.
☐ I would like my lips and mouth kept moist.

I want my family and loved ones:

☐ to know I love them.
☐ to remember me at my best.
☐ to forgive me if I hurt them.
☐ to have joyful memories of my life.
☐ to forgive each other and make peace.
☐ to know I forgive them for any hurt they may have caused me.

I want to be remembered in the following ways:

_____
_____
_____
_____

(complete other side)

I want my family to know that if there is an opportunity to choose, I would prefer to receive my final care:

☐ at home,
☐ in a hospital,
☐ in an extended care facility, or
☐ in a hospice.

I want my family to know the following about the donation of my organs or tissues:

☐ I *wish to donate only the following* organs or tissue if possible (name the specific organs or tissues),_____

☐ I *wish to donate any* organs or tissues if I am a candidate.

☐ I *do not wish to donate* any organs or tissues.

I also want my family to know:

_____
_____
_____
_____
_____
_____
_____
_____
_____

If there is a memorial, I would like to include the following songs, messages, readings etc.

_____
_____
_____
_____
_____
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_____