ADVANCE DIRECTIVE

INSTRUCTIONS

With This Form You Can

Appoint someone to make medical decisions for you if in the future you are unable to make those decisions for yourself. This person should be someone who is familiar with your values and who is willing to take the responsibility.

and / or

Give specific directives about what medical treatment you do or do not want if, in the future, you are unable to make your wishes known.

Directions

- Read each section carefully (several terms are defined on the last page). You may complete Part 1, Part 2 or both. For either to be valid, Part 3 must be completed. The document must be witnessed by two persons who are not your relatives and not volunteers or employees of the health-care institution.

- Give your doctor, your nurse, your case manager, the person you appoint to make your medical decisions for you, your family and anyone else who might be involved in your care, a copy of your advance directive and discuss its contents with them.

- Understand that you may change or cancel this document at any time.

- If you wish further assistance, please contact the Case Management Department.

WORDS YOU NEED TO KNOW

Advance Directive: A written document that tells what a person wants or does not want if he or she becomes unable to make medical decisions.

Artificial Nutrition and Hydration: When food and water are fed to a person through a tube.

Comfort Care: Care that helps to keep a person comfortable but does not necessarily make them better.

CPR (Cardiopulmonary Resuscitation): Treatment to try and restart a person's breathing or heartbeat. CPR may be done using drugs or electric treatment to correct abnormal heart rhythm, pushing on the chest, or introducing a breathing tube into the throat to help breathing.

Durable Power of Attorney for Health Care: An advance directive that appoints someone to make medical decisions for a person if in the future he or she cannot make his or her own medical decisions.

Irreversible Coma: When a person is unconscious with no hope of regaining consciousness even with medical treatment. The body may move and eyes may be open but as far as anyone can tell, the person cannot think or respond. A persistent vegetative state is a kind of irreversible coma.

Life-Sustaining Treatment: Any medical treatment that is used to keep a person from dying. A breathing machine, CPR, and artificial nutrition and hydration are examples of life-sustaining treatments.

Living Will: An advance directive that tells what medial treatment a person does or does not want if he or she is ever unable to make his or her wishes known.

ADVANCE DIRECTIVE

My Durable Power of Attorney for Health Care, and my other wishes.

I, _____, write this document as a directive regarding my medical care.

PART I. MY DURABLE POWER OF ATTORNEY FOR HEALTH CARE

_____ I appoint this person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself.

Name: _____**Phone:**_____

Address: _____

_____

Name: _____**Phone:**_____

Address: _____

_____

PART II. SPECIFIC DIRECTIVES

If you have specific directives regarding medical care, space is provided below.

You should discuss all aspects of your medical care with your doctor. When preparing a specific directive, it is particularly important to talk about life-prolonging treatments. You may wish to receive some of theses treatments, but not others. Some life prolonging treatments to consider include:

- **RESUSCITATION** (sometimes called CPR): Treatment to restore breathing and heartbeat. It may include pushing on the chest, electric treatment to the chest to correct abnormal heart rhythm or introducing a breathing tube into the throat to help breathing.

- **CARDIOVASCULAR SUPPORT:** Treatment to maintain heart function with medications or mechanical devices.

- **VENTILATOR:** A breathing machine (or respirator) to help you breath if you cannot breathe on your own.

- **FOOD AND FLUIDS:** Food and water provided through tubes if you are unable to eat on your own.

- **COMFORT MEASURES:** You may indicate that you wish to be kept as comfortable and free of pain as possible even if such care would prolong your irreversible illness or shorten your life.

I want the person I have appointed, my doctors, my family, and others to be guided by my directives:

_____

_____

_____

_____

PART III. SIGNATURES

A. Your Signature

By my signature below, I show that I understand the purpose and the effect of this document.

Signature: _____ **Date:** _____

Address: _____

_____

B. Your Witnesses: Signatures

I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence, and that he/she appears not to be acting under pressure, duress, fraud, or undue influence. I am not related to the person making this advance directive by blood, marriage or adoption, nor, to the best of my knowledge, am I named in his/her will. I am not the person appointed in this advance directive. I am not a health-care provider or an employee of a health-care provider who is now, or has been in the past responsible for the care of the person making this advance directive.

Signature: _____ **Date:** _____

Address: _____

_____

Signature: _____ **Date:** _____

Address: _____

_____