ADVANCE DIRECTIVE

THIS FORM IS A COMBINED

LIVING WILL
AND
DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

INTRODUCTION
With this form, you can:

- **APPOINT SOMEONE** to make medical decisions for you in the future if you are unable to make those decisions for yourself

and/or

- **INDICATE WHAT MEDICAL TREATMENT YOU WANT OR DO NOT** Would if, in the future you are unable to make your wishes known.

DIRECTIONS

- READ each section carefully.
- TALK to the person you plan to appoint to make sure that he or she understands you wishes and is willing to take the responsibility to make the decision for you.
- FILL IN those choices that you want under Parts l, 2 and 3. Your Advance Directive will be valid for whatever parts you fill in as long as it is properly signed.
- ADD any special instructions in the blank spaces proceeded. You can write additional comments on a separate piece of paper, but you should indicate on the form.
- SIGN the form in the presence of witnesses. Ask the witnesses to sign the form.
- GIVE A COPY of your Advance Directive to your doctor and nurse, the person you have appointed to make your medical decisions for you; your family members; your priest, minister, rabbi or other religious advisor and anyone else who might be involved with your health care. Discuss your wishes with them, too.
- REVIEW this Advance Directive from time to time and understand that you may change or cancel it at any time.

- **SOME TERMS YOU MAY NEED TO KNOW**

ADVANCE DIRECTIVE: A written document that tells what of medical care a person wants or does not want. It deals only with medical decisions, no financial or other decisions and it is used only when the person cannot make these medical decisions.

ARTIFICIAL NUTRITION AND HYDRATION: Food and fluids given to a person through a tube inserted in a vein, the nose or the stomach,

AUTOPSY: An examination of a dead body to find the cause death

COMFORT CARE: Care that helps to keep a person comfortable but does not make him or her better. Comfort care can include bathing and feeding a person and keeping the lips moist. Pain medications (analgesics/sedation are also part of comfort care.

CPR (Cardiopulmonary Resuscitation): Treatment to restart a person's heartbeat or breathing. CPR can include pushing on the chest, putting a breathing tube down the throat, electric shock and other type of treatment.

DURABLE POWER OF ATTORNEY FOR HEALTHCARE: A type of Advance Directive that tells what medical treatment a person wants or does not want if the person cannot make his or her wishes known. This document also follows a person to appoint someone (called a proxy or substitute decision-maker) to make medical decisions if the person cannot make his or her own medical decisions.

LIFE-SUSTAINING TREATMENT: Medical treatment used to keep a person from dying. Examples of life-sustaining treatments are breathing machines (ventilators), CPR, artificial nutrition, and hydration.

LIVING WILL: A type of Advance Directive that tells what medical treatment a person wants or does not want if the person is terminally ill cannot make his or her wishes known.

ORGAN AND TISSUE DONATION: When a person permits his own organs (such as kidneys) or other parts of the body (such as bone) to be remainder after death and transplanted to another person or used in research.

PERSISTENT VEGETATIVE STATE: When a person is unconsolidated with no hope of regaining consciousness even with medical treatment. The person may move and the eyes may be open, but as far as the doctors can tell, the patient is not aware of his or her surroundings and cannot think or respond.

TERMINAL CONDITION: A condition caused by injury or illness that has no cure and from which the doctors expect the person to die even with medical treatment. If a person is suffering from a terminal condition, life-sustaining treatments will only prolong a person’s dying.

ADVANCE DIRECTIVE

I________________________________ am an adult, and I am of sound mind, and write this document as a directive regarding my medical care. I intend the document to be my Living Will and Durable Power of Attorney Healthcare.

(PUT YOUR INITIALS ON THE LINE NEXT TO THE CHOICES YOU WANT

PART 1. APPOINTMENT OF A PROXY (SUBSTITUTE DECISION MAKER)

(Select someone that you trust to make these decisions for you. You can choose a relative or friend, but you cannot appoint you or any other person who is providing you with healthcare.)

I appoint the following named person to make decisions about my medical care if there ever comes a time when I cannot make or communicate those decisions on my own.

Name ________________________________ Work Phone_______________ Home Phone____________
Address ____

____

If the person named above cannot or will not make decisions for me; I appoint this person:

Name ________________________________ Work Phone_______________ Home Phone____________
Address ____

____

__________ Put your initials here only if you do not want to appoint anyone to make decisions.

PART 2: DIRECTIONS FOR MY MEDICAL TREATMENT

I direct the person I have appointed, as well as my doctors, caregivers and others, to be guided by the choices I have indicated by placing my initials on the following:

SECTION A) These are my wishes for medical care if I cannot make my own decisions and I have a **TERMINAL MEDICAL CONDITION:**

1. LIFE-SUSTAINING TREATMENTS

_______ I do not want life-sustaining treatment such as CPR, started. If life-sustaining treatments are started, I want them stopped.
_______ I want the life-sustaining treatments my doctors think are best for me.
_______ Other wishes: _______________

2. ARTIFICIAL NUTRITION AND HYDRATION

_______ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration are started, I want them stopped.
_______ I want artificial nutrition and hydration even if it would be the main treatment keeping me alive.
_______ Other wishes: ____

3. COMFORT CARE

_______I want to be kept as comfortable and free from pain as possible even if such care prolongs my dying or sustains my life.
_______Other wishes: ____

SECTION B) These are my wishes for medical care if I cannot make my own decisions and if I am in a **PERSISTENT VEGETATIVE STATE**

1. LIFE-SUSTAINING TREATMENTS

_______ I do not want life-sustaining treatment such as CPR, started. If life-sustaining treatments are started, I want them stopped.
_______ I want the life-sustaining treatments my doctors think are best for me.
_______ Other wishes: ______________

2. ARTIFICIAL NUTRITION AND HYDRATION

_______ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration are started, I want them stopped.
_______ I want artificial nutrition and hydration even if it would be the main treatment keeping me alive.
_______ Other wishes: ____

3. COMFORT CARE

_______I want to be kept as comfortable and free from pain as possible even if such care prolongs my dying or sustains my life.
_______ Other wishes:____

SECTION C) OTHER WISHES

(You have the right to be involved in all decisions about your medical care, even those not dealing with terminal conditions or persistent vegetative states. For example, you may have strong feelings about whether or not you would want to have a blood transfusion, kidney dialysis (cleaning your blood with a machine) or radiation therapy or chemotherapy (using X-rays or very potent drugs to treat cancer). Use this space to indicate other wishes you may have regarding medical care. If you are attaching extra pages to discuss other wishes, please initial here:_______ and each page at the bottom.

1. ORGAN DONATION

_________I do not wish to donate any organ or limb
_________I wish to donate all of my organs
_________I wish to donate only these organs: ____
_________Other wishes:____

2. AUTOPSY

_________I do not want an autopsy.
_________ I agree to an autopsy, if needed.
_________ Other wishes:

PART 3. SIGNATURES: (You must sign this document in order for it to be legal. The witnesses must see you sign the document and must also sign below.)

A. YOUR SIGNATURE

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

Your signature___________________________ Your Printed Name____________________________Date______
Your address ____

B. YOUR WITNESSES' SIGNATURES

WITNESS # 1 ___________________________ **WITNESS #2**_________________________

SIGNATURE ___________________________ SIGNATURE_________________________

DATE ___________________________ DATE _________________________