ADVANCE DIRECTIVE FOR HEALTH CARE

Your Name: _____ **Date of Birth:** _____

Address: _____

YOUR HEALTH CARE AGENT

Your health care agent can make health care decisions for you when you can not make decisions for yourself. You should pick someone that you trust. Talk to them about your wishes. Tell them that you are making them your agent.

I want this person to be my healthcare agent.

Name: _____

Address: _____

Phone Home: _____ Work Phone: _____

Cell Phone: _____ Email: _____

I want this person to be my alternate agent if the first person cannot do it.

Name: _____

Address: _____

Phone Home: _____ Work Phone: _____

Cell Phone: _____ Email: _____

I want my advance directive to start:

- ☐ When I cannot make my own decisions
- ☐ Now
- ☐ When this happens: _____

Please think carefully about appointing co-agents. Your co-agents need to agree about your treatment. What happens if your co-agents disagree about your medical treatment? What happens when only one of your co-agents is available? How would you want them to make a decision?

APPOINTMENT OF CO-AGENTS

☐ I want the persons listed above, and any additional persons listed in this section, to be my co-agents and for them to make medical decisions together for me.

Additional Co-Agent:

Name: _____

Address: _____

Phone Home: _____ Work Phone: _____

Cell Phone: _____ Email _____

Additional Co-Agent:

Name: _____

Address: _____

Phone Home: _____ Work Phone: _____

Cell Phone: _____ Email _____

Instructions for co-agents to make decisions if they don't agree:

_____

_____

What to do if only one co-agent is available:

_____

_____

INVOLVEMENT OF OTHERS IN MY CARE

I want my agent to consult with these people about my care. My agent can give them information about me:

_____

_____

I don't want my agent to consult with these people about my care. My agent should not give them information about me:

_____

_____

If I don't have an agent, I want my medical information shared with these people:

_____

_____

I don't want this person to bring a court case about my advance directive:

_____

_____

If I need a guardian in the future, I want this person to be my guardian:

_____

_____

I don't want this person to be my guardian:

_____

_____

My primary healthcare doctor or clinician is:

_____

You can decide what kind of treatment you want or do not want at the end of life. You can have your end of life care wishes apply to all situations, or explain when you want them to apply. These are your choices for your care.

END OF LIFE TREATMENT WISHES

My Wishes for End of Life Care (initial your choice)

_____ I want **all** possible medical treatment to sustain life.

_____ I **do not** want the following medical treatment (check your choices):

- ☐ breathing machine
- ☐ feeding tube
- ☐ food by IV
- ☐ fluid by IV
- ☐ other treatments: _____

_____ I **do not** want any medical treatment to extend my life.

My Choices Above for Medical Treatment Apply

_____ To all end of life care decisions

_____ To these specific situations (check your choices):

- ☐ If I am close to death and there is no hope of recovery, and life support would only *prolong* my dying.
- ☐ If I am unconscious and it is very unlikely I will ever be conscious again.
- ☐ If I have a progressive illness that is in an advanced stage and will only get worse, and I am unable to communicate and am completely dependent on others.
- ☐ Other specific situations: _____

_____ To all medical situations and conditions

My Wishes for a Trial Period for Treatment

☐ If I am in a health care crisis that may be life-ending but more time is needed to know if I will get better, I want treatments **started** on a trial basis. This includes the use of breathing machines and feeding tubes.

☐ If I don't get better after a reasonable period of time for the trial, I want all life extending treatments **stopped**.

A do not resuscitate order means that if your heart stops, your doctors won't try to get it started again, and you would die. A DNR order needs to be written by your doctor. If you want a DNR order now, talk to your doctor. If you don't want your doctor to issue a DNR order, or to allow your agent to agree to a DNR for you, indicate that here.

My Wishes about a DNR Order (Do Not Resuscitate Order)

☐ I **do not** want a DNR order written for me at any time.

☐ I **may want** a DNR order in the future, depending on my condition.

☐ I consent to a DNR **now**.

Other instructions about a DNR order:

_____

_____

My Wishes for Pain and Comfort Care

☐ I want care that preserves my dignity and that provides comfort and relief from symptoms that are bothering me.

☐ I want pain medication to be administered to me even though this may have the unintended effect of hastening my death.

☐ I want hospice care when it is appropriate in any setting.

☐ I prefer to die at home if this is possible.

SPECIAL TREATMENT WISHES

My Wishes for Hospitalization

If I need care in a hospital, I **would want to go** to the following hospital or treatment facility:

_____

_____ I **do not** want to go to this hospital or treatment facility:

_____

My Wishes for Medications or Treatment

I prefer these medicines and treatments:

_____

Do not use the following medications or treatment:

_____

My Wishes If I Am Pregnant

If I am pregnant, I would want my treatment outlined above in Part 3 (End of Life Treatment Wishes) changed as follows:

_____

My Wishes for Mental Health Treatment

☐ I want my agent to make decisions for me just like any other care

☐ I do not want my agent to decide about mental health care

☐ My agent should follow these instructions about mental health care:

_____

_____

ORGAN DONATION AND DISPOSITION OF REMAINS

My Wishes about Organ Donation (initial your choice)

_____ I want to donate my organs as follows (check your choices):

- ☐ Any organs needed
- ☐ major organs (heart, lungs, kidneys, etc)
- ☐ tissues such as skin and bones
- ☐ eye tissue

_____ I do not want to donate my organs

_____ I want my health care agent to decide

My Directions for Burial or Disposition of My Remains after I Die:

☐ I have a prepaid funeral contract with _____

☐ These are my wishes about my burial or disposition of my remains:

_____

_____

☐ I want my family or my agent to make all decisions

DISTRIBUTION OF ADVANCE DIRECTIVE

I plan to give a copy of my advance directive to:

☐ My agent. They have agreed to be my agent: **Yes** ☐ / **No** ☐.

☐ My doctor

☐ The online registry

☐ Other: _____

SIGNATURE AND WITNESSES

You must sign this before two adult witnesses. Your agent, spouse, partner, brother, sister, parent, child, grandchild, or reciprocal beneficiary cannot be a witness.

You must sign and date the Advance Directive.

These are my wishes regarding my medical care. I am signing this advance directive of my own free will.

Sign your name here _____ Date _____

Your witnesses must sign and date the Advance Directive.

I affirm that the Principal appeared to understand the nature of this advance directive and to be free from duress or undue influence at the time this was signed.

First Witness Signature _____ Date _____

Print name _____

Address (Town, State) _____

Second Witness Signature _____ Date _____

Print name _____

Address (Town, State) _____

Patients and residents of hospitals, nursing homes, or residential care homes must have this section signed.

I explained the nature and effect of this advance directive to the Principal.

Ombudsman/Clergy/Attorney/Court Designee/Hospital Rep _____ Date _____

ATTACHMENT A: STATEMENT OF VALUES

Do you think your life should be preserved for as long as possible?

What is important to you in order to keep living ? (examples: recognize family or friends, talk to family or friends, wake up from a coma, think for yourself, feed, bathe or take care of yourself)

How do you want your pain managed? What if it makes you less alert or shortens your life?

If you are dying where would you prefer to die?

How do your religious, moral or spiritual beliefs affect the way you feel about your care?

Are there items or music or readings that are special to you?

Should financial considerations be important when making decisions about your medical care?

What else should your agent know about your values when making health care decisions for you?

Attachment B: Giving Your Agent the Authority to Consent to or to Refuse Medical Treatment for You Even If You Object

You can give your agent the ability to allow or refuse medical treatment for you in the future even if you object when that time comes. This changes a very important right. You would be giving up your right to object to having a medical treatment. This would happen only after you are unable to make decisions for yourself. By signing this, you give up the right to change your mind. If you sign this, your agent will do what you say here, even if you changed your mind then. You should think about this very carefully.

If you want to do this, you must have an agent. You need to list the specific kinds of treatment in this attachment. You must give your agent specific permission to allow or object to these treatments. For each treatment that you want to name, you must say directly that you want the treatment, or that you do not want the treatment, even though you are objecting.

Your agent needs to sign this attachment. Your doctor or clinician also needs to sign it. You also must have this attachment signed by an ombudsman, clergy member, lawyer, or a person assigned by the probate court. They need to say that this attachment was explained to you and that you understood what you were signing.

You must say that you are giving up the right to refuse or receive treatment at a time when you do not have the capacity to make your own decision. You must say that you understand that it will be a clinician who makes the decision about whether you have the capacity to make your own medical decisions. This attachment will only become effective if both your clinician and a second clinician say that you do not have the capacity to make healthcare decisions.

1. I give my agent permission to not allow the following treatment, even if I ask for it when I do not have the capacity to make my own decisions:

   _____

   _____

2. I give my agent permission to approve the following treatment, even if I object when I do not have the capacity to make my own decisions:

   _____

   _____

3. My agent can admit me to a hospital for voluntary treatment, even if I am saying I do not want to be admitted. Yes / No.

4. My agent can agree that my discharge from the hospital can be delayed for up to four days. This time allows a decision to be made about whether or not I should be kept in the hospital by court order. Yes / No.

Additional Signature Section for Attachment B:
Treatment Over Your Objection

I am giving up the right to refuse or receive treatment when I am unable to make decisions for myself. I understand a doctor or other medical provider will decide if I can make medical decisions.

Principle _____ Date _____

I agree to authorize or withhold health care over the principal's objection in the event that the principal lacks capacity to make healthcare decisions.

Agent _____ Alternate Agent _____

The principal appeared to understand the benefits, risks, and alternatives to the health care being authorized or rejected by the principal in this provision.

Clinician _____

I am an ombudsman, recognized member of the clergy, attorney licensed in Vermont, or a probate court designee (Please circle the appropriate designation below). I have explained the nature and effect of the provision to the principal, and affirm that the principal appeared to understand the explanation and be free from duress or undue influence.

Ombudsman/Clergy/Attorney/Probate Court Designee/Hospital Rep _____