

HEALTH CARE DIRECTIVE

I, _____, understand this document allows me to do **one**
(Print or type legal name)
or both of the following:

Part 1: Name another person (called the health care agent) to make health care decisions if I am unable to speak for myself. My health care agent must make these decisions for me based on the instructions I provide in Part 2 of this directive, if any, the wishes I have made known to him or her, or must act in my best interest if I have not made my wishes known.

Part 2: Give health care instructions to guide others making health care decisions for me in the event I cannot make decisions for myself.

Part 1: Appointment of Health Care Agent

Note: If you appoint an agent, you should discuss this health care directive with your agent and give them a copy. If you do not wish to appoint an agent, you may leave part 1 blank and go to part 2.

I appoint _____ as my health care agent to make health care decisions for me if I am unable to do it myself.

Address and telephone number of health care agent: _____

(Optional) Appointment of alternate health care agent:

If my health care agent is not reasonably available, I appoint _____
to be my health care agent instead.

Address and telephone number of alternate health care agent: _____

If I have named more than one agent to act simultaneously (check one) _____ each may act independently or _____ they must act jointly.

This is what I want my health care agent to be able to do if I am unable to decide or speak for myself.

- (A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatment, service, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about intrusive mental health treatment.
- (B) Choose my health care providers.
- (C) Choose where I live and receive care and support when those choices relate to my health care needs.
- (D) Have the same right as I would to receive, review and obtain copies of my medical records and to authorize use and disclosure of protected health information from or by any covered entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPPA). This authority will continue as long as this directive has not been revoked.
- (E) To decide whether to donate my organs when I die.

(F) To decide what will happen to my body when I die (cremation or burial).

If I **DO NOT** want my health care agent to have the powers listed in A through F or if I want to limit any power I must say so here. _____

Part 2: Health Care Instructions

Note: Complete Part 2 if you wish to give health care instructions. If you appointed an agent in Part 1, completing this part 2 is optional but would be helpful to your agent. If you choose not to appoint an agent you **MUST** complete some or all of this part 2 if you wish to make a valid health care directive.

Health care goals: Having a sense of what is important to you can help your health care providers make decisions under different and complex circumstances. Read each statement below and on a scale of “0” to “4”, rate how important each of the goals are to you. In this case “4” means “Extremely Important” and “0” means “Not Important At All”. Please remember that reasonable medical care should always include maintaining a person’s comfort, hygiene, and human dignity.

HEALTH CARE GOALS

Not important		Somewhat important		Extremely important
0	1	2	3	4

How important is pain control:

Having pain controlled, even if it reduces my ability to think clearly _____

Having pain controlled, even if it shortens my life _____

How important is the use of life prolonging treatment when:

I have a reasonable chance of recovering both physically and mentally _____

I have some physical limitations but can socially relate to those I care about _____

I can live a longer life no matter what my physical or mental health _____

I have little or no chance of doing everyday activities I enjoy _____

I am not able to socially relate to those I care about _____

I have a terminal illness and treatment will only prolong when I die _____

I have severe and permanent brain injury and there is little chance of regaining consciousness _____

I have severe dementia or confusion and my condition will only get worse _____

Importance of finances and health care

Having my wishes followed regardless of whether or not my finances are exhausted _____

Not being a financial burden to those around me _____

Not having my health care costs affect the financial situations of those I care about _____

MEDICAL TREATMENT PREFERENCES

It is helpful for others to know if and why you have strong feelings about certain medical treatments. Some of the more difficult medical decisions are about treatments used to prolong life, such as those listed below. Most medical treatments can be tried for a while and then stopped if they do not help. Discuss these with a health care professional to make sure you understand what they might mean for you given your current or future health conditions.

Medical procedure When it is used and its effects my feelings about this procedure

<p>Ventilator/Respirator A breathing machine</p> <p>A Do Not Intubate (DNI) order is put on your medical record when you do not want this procedure.</p>	<p>When you cannot breathe on your own</p> <p>You cannot talk or eat by mouth on this machine.</p>	
<p>Nutrition support and Hydration</p>	<p>When you cannot eat or drink by mouth, feeding solutions can provide enough nutrition to support life indefinitely.</p> <p>Feeding solutions can be put through a tube in your stomach, nose, intestine, or veins.</p>	
<p>Cardiopulmonary Resuscitation (CPR)</p> <p>A Do No Resuscitate (DNR) order is put on your medical record when you do not want this procedure.</p>	<p>Actions to make your heart and lungs start if they stop including pounding on your chest, electric shocks, medications, and a tube down your throat.</p>	
<p>Dialysis</p>	<p>A mechanical means of cleaning the blood when the kidneys are not working.</p>	

It would be helpful for the people providing for you to know as much about your beliefs as you can share. Please address the following so they can provide you with the care you would want. You may say as much or as little as you like.

My religious and spiritual beliefs:

My thoughts on when life would no longer be worth living:

I want to be as independent as possible, but in the event I cannot, some of the things I worry about are:
(examples: financial burden, can't walk by myself, can't talk, too medicated)

My preferences for other things relating to my health care:

Who I would like my doctor to be_____

Where I would like to receive health care_____

Where I would like to die_____

I would like to donate my organs if appropriate and want my health care to support this: yes/no

I would like my body buried: yes/no I would like to be cremated: yes/no

Any other comments:

Reminder: You should discuss this document with your doctor. Keep this document in a safe place but not in a safe deposit box. Signed copies should be given to your doctor, family, close friends, health care agent and alternate. It should also be apart of your medical records at your doctor's office and at the facility you receive your medical care.

Making the Document Legal

This document must be signed and either verified by a notary public (option 1) **or** witnessed by two witnesses (option 2) and dated.

I am thinking clearly and agree to everything that is written in this document, and I have made this document willingly.

My signature: _____

Date signed: _____ My date of birth: _____

If I cannot sign I can ask someone to sign for me.

Signature of person I asked to sign for me _____

Printed name of person I asked to sign for me _____

Option 1

In my presence on _____ (date), _____ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person to sign on his/her behalf. I am not named as health care agent or alternate in this document.

Signature of notary public: _____ stamp:

Option 2

Two witnesses must sign and they must certify that the information below is correct.

(A) In my presence on _____ (date), _____ (name) acknowledged his/her signature on this document or acknowledged that he/she authorized the person signing this document to sign on his/her behalf.

(B) I am at least 18 years of age.

(C) I am not named as health care agent or alternate in this document.

(D) No more than one of us signing this is a health care provider giving direct care to the person listed above.

Signature of witness one _____

Print name and address of witness one _____

Signature of witness two _____

Print name and address of witness two _____
