Advance Directive for **Health Care**

Respecting

Your

Right To:

Choose Your Health Care Agent

Choose the Authority Given to Your Health Care Agent

Choose Your Preferences Related to Treatment & Care

Printed Name

Birthdate

Name: _____

Getting Oriented

PART ONE- Choose a Health Care Agent (the person(s) you choose to make health care decisions for you when needed).

PART TWO- Select some medical treatment preferences.

PART THREE- Guidance for your Health Care Agent

PART FOUR (Required)- Your signature and two witnesses.

You may fill out Part One, Part Two, or both, but if you have filled out ANY section of this form then Part Four MUST be filled in to make it legally valid.

Explanation and Directions for this Advance Directive:

This document goes into effect only when you are unable to (or choose not to) make health care decisions for yourself.

1. This is an important legal document.
2. This is a way to communicate health care preferences to your health care providers and others who care about you (e.g. friends, family).
3. This document does NOT give permission for your health care agent to make business or financial decisions on your behalf

Steps to Take After Completing This Advance Directive:

1. Talk about your advance directive and your health care related goals and preferences with:
   - ❑ Your Health Care Agent and Backup Agent
   - ❑ Your Friends
   - ❑ Your Family
   - ❑ Your Emergency Contact
2. Give copies of your advance directive to:
   - ❑ Your Health Care Agent
   - ❑ Your Backup Health Care Agent
   - ❑ Your health care providers
3. Keep a copy of your advance directive where it can easily be found (e.g. on the refrigerator).
4. If you are going to the hospital or a nursing home, take a copy of this document with you and ask that it be placed in your medical records.

Remember: You may revoke this completed form (advance directive) at any time by:

1. Completing a written statement declaring your preference to revoke that is signed and dated; OR
2. Stating your desire to revoke the document in the presence of a witness 18 years of age or older who completes a written statement of your expression within 30 days of your declaration. The statement should be signed and dated; AND
3. Communicating the revocation to your attending physician and other health care providers.

How Often Should You Consider Making Changes to Your Advance Directive?

It is good to review and update your advance directive when one of the following occurs:

- ❑ *Decade*- at the start of a new decade of your life (every 10 years)
- ❑ *Death*- if your health care agent dies or if your choices have changed after the death of a loved one
- ❑ *Divorce*- if you marry someone other than your health care agent or if you divorce your healthcare agent, then this document is automatically revoked
- ❑ *Diagnosis*- if you are diagnosed with a chronic or serious illness
- ❑ *Decline*- if your health gets worse over time, especially if you are no longer able to live on your own.

Need help completing this document?

Contact a Respecting Choices advance care planning facilitator at **wellstar.org/acp** to ask a question.

PART ONE: My Choice for Health Care Agent

(Part 1 will be effective even if Part 2 is not completed)

Who Should You Choose as Your Health Care Agent?

- Someone who knows you well, and will respect your goals and values
- Someone you trust to make decisions in difficult circumstances
- Someone who will be a good advocate for you and follow your decisions, even if he/she may not agree with them
- Someone 18 years or older

Who Cannot Be Your Health Care Agent?

- A health care provider if he/she is directly involved in your care
- Someone younger than 18 years old

If I can no longer make my own health care decisions (or I choose not to), this directive names the person I authorize to make these choices on my behalf; even if I do not fill out my treatment preferences in the next part. This person will be my health care agent.

The Person I Choose as My Health Care Agent:

Name_____ Relationship_____

Telephone (Cell)_____(Work)_____(Home)_____

Address_____

Email Address (optional)_____

If my health care agent cannot be contacted within a reasonable time period or for any reason is unable or unwilling to act as my health care agent, then I select the following back up health care agents to be contacted in order of choice.

Back-Up Agent # 1:

Name_____ Relationship_____

Telephone (Cell)_____(Work)_____(Home)_____

Address_____

Email Address (optional)_____

Back-Up Agent # 2:

Name_____ Relationship_____

Telephone (Cell)_____(Work)_____(Home)_____

Address_____

Email Address (optional)_____

❑ **By checking this box, I'm indicating that I do <u>not</u> have a health care agent. Instead, please allow my selections on Part Two to guide my health care decisions.**

Name: _____

What My Health Care Agent Can Do:

I understand that I have chosen a health care agent to make decisions for me related to my health care. He/she will have the same authority to make any health care decision that I could make. For example:

- Take my instructions and what he/she knows of my preferences/values to act in my best interest.
- Authorize, request, refuse, withdraw, and/or withhold any and all types of medication, treatment, procedures or health care.
- Consent, negotiate and/or contract for any health care facility or service for me, such as assisted living, skilled nursing facility, hospital, hospice or nursing home. These actions will not make my health care agent liable to pay for these services.
- Review and release my medical records as needed for my medical care.

Note: Under Georgia law, a court can take away the powers of your health care agent if it finds he/she is not acting in accordance with your preferences. Your health care agent DOES NOT have the power to make decisions regarding behavioral treatment, sterilization, treatment or involuntary hospitalization for mental or emotional illness, or addictive disease.

What My Health Care Agent Can Do After I Die:

I understand that my health care agent can make decisions about the following (unless I have initialed to indicate I do not want him/her to have that authority/ability):

1. **Autopsy-** *My health care agent WILL have the power to authorize (give permission) for an autopsy*
2. **Organ Donation and/or Body Donation-** *My health care agent WILL have the power to donate my body for use in a medical study and/or donate any of my organs*
3. **Final Disposition of My Body-** *My health care agent WILL have the power to authorize the final disposition of my body including funeral arrangements and burial or cremation*

Only initial those things that you DO NOT want your health care agent to be able to do after you die

1. **Autopsy:** _____(Initial) I do NOT give the authority to my health care agent to authorize an autopsy (unless required by law).

2. **Organ Donation and Body Donation:**

   a. _____ (Initial) I do NOT give authority to my health care agent to donate my body for use in a medical study.

   b. _____ (Initial) I do NOT give authority to my health care agent to donate any of my organs.

3. **Final Disposition of My Body**: _____ (Initial) I do NOT give authority to my health care agent to make decisions about final disposition of my body.

   I want the following person to make decisions about the final disposition of my body:

   Name_____Phone_____

   Address_____

   Initial your preference for the final disposition of your body:

   _____ (Initial) I want to be buried. _____ (Initial) I want to be cremated.

Name: _____

PART TWO: My Treatment Preferences

(Part 2 will be effective even if Part 1 is not completed)

This is your opportunity to make your preferences clear. Your health care agent and your doctors will refer to this section as a guide when you cannot make informed decisions. If you did NOT name a health care agent or back-up agent or if he/she cannot be reached, you can direct your care with the choices you indicate below. **WITH ANY CHOICE BELOW**, I understand I will be kept clean and comfortable and continue to receive medications for pain control and comfort.

Initial each statement you choose as your treatment preferences if you are in these situations:

If I have a **terminal illness** (incurable or irreversible condition) and my attending physician and another physician believe (and write in the medical record) that I will die within a short period of time, this is my choice:

1. _____ **I want to extend my life for as long as possible** using all treatments that the doctors believe are reasonable. Some examples are a machine that breathes for me (respirator/ventilator), feeding tubes, blood products, medications, and/or fluids given to me through an IV or treatments for chronic medical conditions.

OR

2. _____ **I want to allow my natural death** to occur by refusing or stopping all treatments except any I choose below:

   a. _____If I cannot get nutrition by mouth, I want to receive nutrition by tube/other medical means.
   b. _____If I cannot drink fluids by mouth, I want to receive fluids by tube/other medical means.
   c. _____If I need assistance to breathe, I want to have a ventilator/respirator used.
   d. _____If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

If I am in a **state of permanent unconsciousness** (an incurable or irreversible condition) in which my attending physician and another physician believe (and write in the medical record) that I am not expected to recover the ability to know who I am, who my friends and family are or where I am, this is my choice:

1. _____ **I want to extend my life for as long as possible** using all treatments that the doctors believe are reasonable. Some examples are a machine that breathes for me (respirator/ventilator), feeding tubes, blood products, medications, and/or fluids given to me through an IV or treatments for chronic medical conditions.

OR

2. _____ **I want to allow my natural death** to occur by refusing or stopping all treatments except any I choose below:

   a. _____If I cannot get nutrition by mouth, I want to receive nutrition by tube/other medical means.
   b. _____If I cannot drink fluids by mouth, I want to receive fluids by tube/other medical means.
   c. _____If I need assistance to breathe, I want to have a ventilator/respirator used.
   d. _____If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

Name: _____

My additional preferences and wishes regarding my health care:

_____

_____

_____

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Attach Additional pages about treatment preferences (signed and dated) as needed

PART THREE: Binding Guidance for Health Care Agent

When making health care decisions for me, my health care agent must think about what action would be consistent with past conversations we have had, my treatment decisions as expressed in PART TWO, my religious and other beliefs and values I hold, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that he/she believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

If I have appointed a health care agent who gives instructions that differ from my treatment preferences in PART TWO of this Advance Directive, then I direct that (**Initial only one of the following**):

(Initial)_____	Follow Advance Directive: This Advance Directive will override instructions my Health Care Agent gives about prolonging my life.
(Initial)_____	Follow my Health Care Agent: My Health Care Agent has authority to override this Advance Directive.

PART FOUR: Making this Advance Directive Complete and Legally Valid

Sign and date (or acknowledge signing and dating) this form in the presence of two witnesses. Both witnesses must be emotionally and mentally capable and at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

A witness:

- Cannot be a person who was selected to be your health care agent or back-up agent(s)
- Cannot be a person who will gain financially from your death
- Cannot be a person who is directly involved in your health care

Only one of the witnesses may be an employee, agent or medical staff member of the hospital, skilled nursing facility, hospice or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).

My Signature and Date

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before the date indicated beside my signature. This form does not revoke an advance directive for behavioral health treatment.

I am emotionally and mentally capable to make this advance directive and I understand its purpose and effect. I agree with everything written in this document and have completed this document of my free will.

Signature_____ Date _____

My Witnesses

The maker of this Advance Directive signed this form in my presence or acknowledged signing this form to me. I believe this person to be emotionally and mentally capable of making this advance directive. I am at least 18 years old and I signed this form willingly and voluntarily.

Witness Number One:

Signature_____Date_____

Printed Name of
Witness_____

Address_____

Witness Number Two:

Signature_____ Date_____

Printed Name of
Witness_____

Address_____

********This form DOES NOT need to be notarized********