ADVANCE HEALTH-CARE DIRECTIVE

HOW YOU USE THIS FORM

You can use this form if you wish to name someone to make health-care decisions for you in case you cannot make them for yourself. This is called giving someone Power of Attorney. This person is called your Agent.

You can also use this form to state your wishes, preferences, and goals for health care, and to say if you want to be an organ donor when you die.

YOUR NAME AND BIRTHDAY

Name:

Date of birth:

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

Part 1 allows you to appoint someone else to make health-care decisions for you. You do not have to respond to every item if you prefer not to.

1. **NAMING AN AGENT**

   I want the following person to make health-care decisions for me if I cannot make decisions for myself:

   Name:

   Address (optional):

   Phone Number (optional):

   Email (optional):

2. **NAMING AN ALTERNATE AGENT**

   I want the following person to make health-care decisions for me if I cannot and my Agent is not willing, able, or reasonably available to make them for me:

   Name:

   Address (optional):

   Phone Number (optional):

Email (optional)

3. **ADDITIONAL POWERS**

My Agent can do the following things ONLY if I have initialed or marked them below:

(___) Admit me as a voluntary patient to a facility for mental health treatment for no more than 7 days, or 14 days, or 30 days (circle one)

(___) Place me in a nursing home for more than 100 days if I am not terminally ill, even if my needs can be met somewhere else, and even if I object to being placed in the nursing home

(___) Agree to my participating in medical research even if it will not directly benefit me and risks more than a little harm to me

4. **SPECIAL LIMITS ON AGENT'S AUTHORITY**

I give my Agent the power to make all health-care decisions for me if I cannot make those decisions for myself, except the following:

Limitations:

(If you do not add any limitations here, your Agent will be able make all health-care decisions that an Agent is permitted to make under state law.)

5. **HEALTH INFORMATION SHARING**

My Agent may obtain, examine, and share information about my health needs and health care (initial or mark one):

(___) Whenever my Agent reasonably believes it is in my best interest

(___) Only if I cannot make health-care decisions for myself

PART 2: HEALTH CARE INSTRUCTION

Part 2 lets you state your priorities for health care and the types of health care you do and do not want.

1**. INSTRUCTIONS ABOUT LIFE-SUSTAINING TREATMENT**

This section gives you the opportunity to say how you want your Agent to act in your behalf while making decisions for you. You may mark each item with a check, an X, or your initials. You also may leave any item blank if you prefer.

If I have a condition that is not curable and is expected to cause me to die soon even if

treated:

(___) I want to receive all medical treatments available to continue my life.
(___) I do not want medical treatment if its only purpose is to continue my life.
(___) If I cannot swallow, I do not want to be given food or liquids through a tube or other means if its only purpose is to continue my life.
(___) I want to receive care that will help me be comfortable even if it shortens my life.
(___) Other (write what you want or do not want).

If I am unconscious and am not expected to be conscious again:

(___) I want to receive all medical treatments available to continue my life.
(___) I do not want medical treatment if its only purpose is to continue my life.
(___) If I cannot swallow, I do not want to be given food or liquids through a tube or other means if its only purpose is to continue my life.
(___) I want to receive care that will help me be comfortable even if it may shorten my life.
(___) Other (write what you want or do not want):

If I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends:

(___) I want to receive all medical treatments available to continue my life.
(___) I do not want medical treatment if its only purpose is to continue my life.
(___) If I cannot swallow, I do not want to be given food or liquids through a tube or other means if its only purpose is to continue my life.
(___) I want to receive care that will help me be comfortable even if it may shorten my life.
(___) Other (write what you want or do not want):

2. INSTRUCTION ABOUT PRIORITIES

You can use this section to indicate what is important to you, and what is not important to you. This information can help your Agent make decisions for you if you cannot make them for yourself. It also helps others understand your preferences.

You may mark each item with a check, an X, or your initials. You also may leave any item blank if you prefer.

Staying alive as long as possible even if I have substantial physical limitations is:

(___) Very important
(___) Somewhat important
(___) Not important

Staying alive as long as possible even if I have substantial mental limitations is:

(___) Very important
(___) Somewhat important
(___) Not important

Being free from significant pain is:

(___) Very important
(___) Somewhat important
(___) Not important

Being independent is:

(___) Very important
(___) Somewhat important
(___) Not important

Having my family and friends involved in making decisions about my care is:

(___) Very important
(___) Somewhat important
(___) Not important

3. OTHER INSTRUCTIONS

You can use this section to provide any other information about your goals, preferences, values, and wishes for treatment about the health care you want or do not want. You can also use this section to name anyone who you do not want to make decisions for you under any conditions.

4. OPTIONAL, ADDITIONAL GUIDANCE FOR YOUR AGENT

You may mark each item with a check, an X, or your initials. You also may leave any item blank if you prefer.

(___) The instructions I stated in this document should guide the person making decisions for me. However, I give my Agent permission to be flexible in applying these instructions if they think it would be in my best interest based on what they know about me.

(___) The instructions I stated in this document should guide the person making decisions for me. I want them to follow them exactly as written if possible, even if they think something else is better.

PART 3: ORGAN DONATION

Part 3 allows you to donate your organs when you die. If you do not want to use this form to make a donation, you may leave it blank.

You may mark each item with a check, an X, or your initials. You also may leave any item blank if you prefer.

Even if procedures necessary to evaluate, maintain, or preserve my organs, tissues, or other body parts conflict with other instructions I have put in this form or another document, upon my death:

(___) I donate my organs, tissues, and other body parts, except for those listed below (list any body parts you do NOT want to donate):

(___) I donate the following organs, tissues, or body parts only (list any body parts you DO want to donate):

(___) I do not want my organs, tissues, or body parts donated to anybody for any reason.

My organs, tissues, and body parts may be used for (mark each item you want with a check, an X, or your initials):

(___) Transplant
(___) Therapy
(___) Research
(___) Education
(___) All of the above

PART 4: SIGNATURES REQUIRED ON THIS FORM

YOUR SIGNATURE:
Sign your name:

Today's date:

SIGNATURE OF A WITNESS

You need a witness if you are using this form to name an Agent. The witness cannot be the person you are naming as Agent or the Agent's spouse, domestic partner, or someone the Agent lives with as a couple. If you live in a nursing home, the witness cannot be an employee of the home or someone who owns or runs the home.

Witness's name:

Witness's signature:
(Only sign as a witness if you believe that the person filling out this form is doing so voluntarily.)

Witness address:

Date witness signed:

PART 5: INFORMATION FOR AGENTS

1. If this form appoints you as an Agent, you may make decisions about health care for the person who appointed you when they cannot make their own.

2. If you make a decision for the person, follow any instructions the person gave, including any in this form.

3. If you don't know what the person would want, make the decision that you think is in the person's best interest. To figure out what the individual's best interest, consider the individual's values, preferences, and goals if you know them or can learn them. Some of these preferences may be on this form. You should also consider any behavior or communications from the person that indicate what they currently want.

4. If this form appoints you as an Agent, you can also get and share the individual's health information. But unless the person has said so in this form, you can only get or share this information when the person cannot make their own decisions about their health care.