



# ADVANCE DIRECTIVE

## YOUR CHOICE, YOUR VOICE

A guide to help you take charge of your future medical care.  
Living Will and Power of Attorney for Healthcare included.

KNOW YOUR CHOICES.  
SHARE YOUR WISHES.

KEEP CONTROL.  
GET PEACE OF MIND  
AND MAKE SURE YOUR WISHES ARE HONORED.

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## INSTRUCTIONS AND FORMS

These forms will help you decide how to direct your medical care in the event you are not able to speak for yourself.

While it is hard to think about what might happen with your health in the future, these forms give you choices that you may wish to make.

Please take some time to read this booklet and fill out the forms. Be sure to ask questions, and talk about these choices with your family, close friends and doctors. You will keep the original, and we will keep a copy in your medical record.

## DEFINITIONS

### LIVING WILL

This form allows you to make your wishes known regarding your healthcare in the event you can no longer do so. **The form goes into effect if you have a terminal illness, are permanently unconscious (in a coma) or in a persistent vegetative state. The law says your doctor must follow your wishes.**

### POWER OF ATTORNEY FOR HEALTHCARE

The Power of Attorney for Healthcare lets you choose a person who will make medical choices for you if you are not able to do so. The person you choose is called your Surrogate. You may also choose a second Surrogate in case the first person you choose cannot be reached.

Becoming incapacitated, even temporarily, can happen to anyone at any time. If you are hospitalized and become unable to speak for yourself, your healthcare providers will ask your closest relatives or friends to help them decide how to proceed with your treatment. Sometimes loved ones do not agree about a family member's care, and that is why Advance Directives are important — they tell others about your choices for health care when you cannot. Identifying a person who you trust to be your Power of Attorney for Healthcare ensures that you have someone of your choosing available to speak for you and who knows your wishes if you cannot speak for yourself. Your ability to speak through your Power of Attorney for Healthcare is as important to your healthcare team as it is to you.

### INSTRUCTIONS TO MY SURROGATE (OPTIONAL)

These directions give you a way to tell your Surrogate about your wishes, so that they may carry them out. These instructions are not legally binding (required by law), but help them get a sense of what you would want when you can no longer speak for yourself. We cannot plan for every change in your health.

# LIVING WILL: YOUR WISHES ABOUT HEALTHCARE

I, (Printed Patient's Name) \_\_\_\_\_ (Date of Birth) \_\_\_\_\_, being of sound mind, willfully and voluntarily make this declaration to be followed if I can no longer make decisions for myself.

I direct my doctor and healthcare team to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying **if I should be in a state of permanent unconsciousness (coma) or have a terminal illness.**

I direct that treatment be limited to efforts to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

**In addition, if I am in the condition described above, I feel strongly about the following forms of treatment:**

*(Please check any preferences below.)*

- I  Do  Do not want cardiac resuscitation (CPR).
- I  Do  Do not want to be put on a ventilator (breathing machine).
- I  Do  Do not want tube feeding or any other artificial or invasive form of hydration (water). This includes a feeding tube put into the stomach.
- I  Do  Do not want blood or blood products.
- I  Do  Do not want kidney dialysis.
- I  Do  Do not want blood drawing or getting stuck by needles.
- I  Do  Do not want any form of surgery or invasive diagnostic tests.

I make this declaration on (Date) \_\_\_\_\_

Signature (Patient's Name) \_\_\_\_\_

**I state that the declarant knowingly and voluntarily signed this document by writing his/her signature or mark in my presence.**

Witness' Signature \_\_\_\_\_

\_\_\_\_\_  
(Address) (City) (State) (Zip Code)

Witness' Signature \_\_\_\_\_

\_\_\_\_\_  
(Address) (City) (State) (Zip Code)

# POWER OF ATTORNEY FOR HEALTHCARE

Power of Attorney for Healthcare of (Patient's Name) \_\_\_\_\_ Date \_\_\_\_\_

## 1. DESIGNATION OF SURROGATE

I understand my right to make my own decisions to accept or refuse health care treatments. If I become unable to make a treatment decision, I appoint as my Surrogate for healthcare decisions:

Surrogate's Name (Print) \_\_\_\_\_

\_\_\_\_\_  
(Address) (City) (State) (ZIP Code)

\_\_\_\_\_  
(Email) (Phone) (Relationship)

## 2. SUBSTITUTE OF SURROGATE (OPTIONAL)

If he/she cannot be reached or is unwilling or unable to make decisions, I appoint the following person as my substitute surrogate:

Substitute Surrogate's Name (Print) \_\_\_\_\_

\_\_\_\_\_  
(Address) (City) (State) (ZIP Code)

\_\_\_\_\_  
(Email) (Phone) (Relationship)

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness' Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness' Signature \_\_\_\_\_ Date \_\_\_\_\_

**We suggest that you make copies for yourself, your family, your surrogate and your healthcare team.**

## INSTRUCTIONS TO MY SURROGATE (OPTIONAL)

### MY MOST IMPORTANT VALUES

The most important things to me about my health and healthcare are: *(Check as many as you wish.)*

To live as long as I can, even if I am less able or not able to function. *(You may explain more.)*

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To keep my dignity. *(You may explain more.)*

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To have a good quality of life. *(You may explain more.)*

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To be able to communicate with other people. *(You may explain more.)*

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To be free from pain. *(You may explain more.)*

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Other. *(Please explain.)*

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