Advance Healthcare Directive - Part I

SELECTING MY HEALTHCARE DECISION MAKER

At some point in your lifetime, you may become unable to make all of your own decisions about your medical treatment and care.

Choosing someone ahead of time who you would like to make decisions for you means:

1. You can select a person who understands your values and knows what you would want, and
2. Your medical care team will know who you prefer to make decisions about your health.

IMPORTANT INFORMATION ABOUT MY HEALTHCARE DECISION MAKER

In choosing your healthcare decision maker, it is important to know:

- Your Healthcare Decision Maker WILL NOT be able to make decisions for you unless you are determined to lack capacity to make your own decisions by your medical care team.
- If you REGAIN YOUR CAPACITY, then you will make your own healthcare decisions again.
- You may CHANGE or REVOKE your Healthcare Decision Maker at anytime while you have capacity.
- If you choose, you can select someone to make your healthcare decisions for you now, even though you are still capable.

Designation of Healthcare Decision Maker (Agent)

With this form I am choosing the person, and if they are unavailable, any alternate persons I would like to make my healthcare decisions for me. I understand that I may not choose an owner, operator or employee of a healthcare institution (such as my doctor or nurse) where I am receiving care UNLESS that person is related to me by blood or marriage.

I appoint the following person as my Healthcare Decision Maker to make healthcare decisions for me:

_____ _____

(name) (address)

_____ _____

(phone) (alternate phone)

If my Healthcare Decision Maker cannot or will not make a healthcare decision for me or if I revoke my Healthcare Decision Maker's authority, then I appoint these persons as my alternate Healthcare Decision Makers, to serve as follows:

First Alternate:

Name: _____ Address: _____

Phone: _____ Alternate Phone: _____

Second Alternate:

Name: _____ Address: _____

Phone: _____ Alternate Phone: _____

You may revoke your selection of a Healthcare Decision Maker at any time.
USE THE BACK OF THIS FORM TO DETERMINE YOUR DECISION MAKER'S AUTHORITY

PATIENT IDENTIFICATION

Name: _____

Date of Birth: _____

PRESBYTERIAN

ADVANCE HEALTHCARE DIRECTIVE

MY HEALTHCARE DECISION MAKER'S AUTHORITY

I, _____ , understand that with this form I can choose to limit the authority of any person I select to be my Healthcare Decision Maker. If I choose not to limit my Healthcare Decision Maker's authority, then they will be able to make ALL healthcare decisions for me.

I. I want my Healthcare Decision Maker's authority to be effective:

(Initial Your Choice below)

_____ When my primary or attending physician and one other licensed member of my medical care team determine that I do not have the capacity to appreciate the risks and benefits of medical treatment (capacity). I understand if my capacity returns, I will again make my own medical care decisions.

_____ My Healthcare Decision Maker's authority is effective immediately, even though I have capacity at this time.

II. The limitations I choose for my Healthcare Decision Maker's authority are:

(Initial Your Choice below)

_____ No limitations. I want my Healthcare Decision Maker to be able to make decisions about everything, including:

- tests and treatment
- surgery
- medication
- nursing and home care needs
- orders not to resuscitate
- life saving and life prolonging medical treatment
- the provision or withdrawal of artificial nutrition and hydration

_____ Limitations. I want my Healthcare Decision Maker's authority limited in the following ways:

_____

_____

_____

_____

I understand that I should review these decisions with my physicians so they can help me ensure I have made selections that my medical care team understands.

PATIENT IDENTIFICATION

Name: _____

Date of Birth: _____

PRESBYTERIAN

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Advance Healthcare Directive - Part II

WISHES AND VALUES

The following are some specific instructions for my Healthcare Decision Maker (Agent) and/or physician(s) providing my medical care:

If you agree with the statements below, place your initials on the line next to the statement.

Instructions:

_____ I chose not to provide any written instructions. My Healthcare Decision Maker will make decisions based on my oral instructions or what is considered my best interests.

1. Stopping Life Prolonging Efforts:

_____ If I reach a point where it is likely that I will not recover my ability to interact meaningfully with my family, friends, and environment, I want to stop or withhold all treatments, other than comfort care, that might be used to prolong my existence. Treatments I would not want if I were to reach this point include but are not limited to tube feedings, IV hydration, respirator/ventilator, and antibiotics.

2. Pain and Symptom Control:

_____ If I reach a point where efforts to prolong my life are stopped, I want medical treatments and nursing care that will make me comfortable. The following are important to me for my comfort:

_____

_____

3. Cardiopulmonary Resuscitation (CPR):

_____ I want CPR attempted unless my physician determines any one of the following:

- I have an incurable illness or injury and am dying; OR
- I have little or no chance of long- term survival if my heart stops and the process of resuscitation would cause significant suffering.

_____ I want CPR attempted if my heart stops, even if survival is unlikely.

_____ I do not want CPR attempted if my heart stops, but rather, want to permit a natural death.

4. Other instructions or limitations I want my Healthcare Decision Maker to follow:

_____

_____

_____

5. If it is possible I prefer to be cared for in the following location:

_____

_____

_____

PATIENT IDENTIFICATION

Name: _____

Date of Birth: _____

PRESBYTERIAN

ADVANCE HEALTHCARE DIRECTIVE

6. When I am nearing my death, I want the following: (List the type of care, rituals, etc., that are important for you.)

_____

_____

_____

7. Persons I want my Healthcare Decision Maker to include in the decision process:

I ask that my Healthcare Decision Maker make a reasonable attempt to include the following people in my healthcare decisions, if there is time; however, I understand that all final decisions must be made by my Healthcare Decision Maker.

_____

_____

8. Faith

I am of the _____ faith, and am a member of the congregation, synagogue, or worship group. The phone number of above group is _____ .

Please attempt to notify them.

9. Medical Records:

Upon my death, I want the following people to have access to my medical records

_____

_____

_____

10. Donation of my organs or tissue:

_____ I consent to donate any organs or tissue, if I am a candidate.

_____ I do not want to donate any organ or tissue.

_____ I consent to donate only the following organs or tissue if possible: _____

_____

_____ I choose to let my Healthcare Decision Maker decide.

_____

Signature

_____

Date

PATIENT IDENTIFICATION

Name: _____

Date of Birth: _____

PRESBYTERIAN

ADVANCE HEALTHCARE DIRECTIVE