Please read the instructions before filling out this form.
This form emphasizes quality of life.

ADVANCE HEALTH CARE DIRECTIVE

(Living Will with Durable Power of Attorney for Health Care)

THE TERMS OF MY DIRECTIVE ARE ON PAGE 2

My Name is:_________________________ _________________________
Full Name Preferred First Name

My Agent (Surrogate or Proxy) is: ______________________________________

Agent's Phone Numbers:____
Cell Home Work

Address:____

My Alternate Agents are: (If the designated agent is unwilling or unable to serve) (Optional)

1st Alternate: Name: ____
Phone Numbers:____
Address: ____

2nd Alternate: Name: ____
Phone Numbers: ____
Address: ____

My Primary Physician is :
Dr. ____
Phone:____
Address:____

THE KEY TERMS OF MY DIRECTIVE ARE ON PAGE 2
Date and Signature are on page 3

My Name Is: ___________________________________

AUTHORITY OF MY AGENT: When I am unable to make my own decisions, my Agent has authority to make all medical decisions for me. This means to agree to, refuse, withdraw or consent to any medical care, such as surgery, medications, or procedures, even if deciding to stop or withhold treatment might hasten my death.

INSTRUCTIONS TO MY AGENT: I have discussed my philosophy, goals and wishes with you, and put them in my letter to you, including, if checked here, ____, my wishes should I be stricken with dementia.

If the choice I would make in any given circumstance is unclear, you are instructed to decide based on what you believe to be in **my best interest**, given my philosophy, goals and wishes known to you.

You, my Agent, (initial one) ______ are authorized, or _______are NOT authorized to override any specific decisions stated in this Advance Health Care Directive (If neither is initialed then my Agent is authorized).

INSTRUCTIONS TO MY PERSONAL AND ATTENDING PHYSICIANS:
The QUALITY of my LIFE is **more important** to me than living as long as possible.
I understand that doctors, nurses and others have a professional obligation to keep me alive. It is my directive that such obligation is less important than my autonomy as expressed by my choices below.

Always apply palliative care.

MY DIRECTIVES:
INITIAL ALL THAT APPLY: (These choices, 3-5d are progressive; check as far down as you wish, but leave no blanks in between.)

1. _____**TIME-LIMITED TRIALS**. I authorize time-limited trials to see if medical interventions might return me to the minimum quality of life I desire, as discussed with my agent. How long a trial goes is to be determined by my agent, in consultation with doctors.
2. _____**VEGETATIVE STATE.** Allow a natural death with palliative care if I am in a vegetative or a near vegetative state from which I am unlikely to recover.
3. _____ **DISCONTINUE MEDICAL INTERVENTIONS.** If it appears that medical interventions are prolonging my life but not returning me to the quality of life I desire, then discontinue the interventions and begin comfort care only.
4. _____ **ASSISTED FEEDING**. If I am unable to feed myself, then spoon feed me whatever I seem to enjoy, and no more. Do not feed me or apply medical interventions, such as tubes and IVs, so that I might live longer.
5. _____ If this sentence is initialed and any of the choices a, b, c or d are initialed, **they are not to be implemented** if they put my agent or any of my caregivers at criminal risk.

WITHHOLD ALL NUTRITION & HYDRATION including medical interventions such as tubes and IVs. Do not encourage or entice me to eat or drink. Keep food odors out of out of my room.

a. _____ Whenever I show no desire to eat or drink.
b. _____ Even if I show a desire to eat or drink.
c. _____ Even if I say, utter, or otherwise indicate that I wish to eat or drink.
d. _____ Even if I say, utter, or otherwise indicate that I wish to live.

My Name Is: ________________________________

ADDITIONAL PROVISIONS (or attach a page): ____

____

____

MISCELLANEOUS PROVISIONS:

LIVING ARRANGEMENTS: If I am in an institution or any facility that refuses to carry out my directives, then move me home or to a facility that will.

CONSERVATORSHIP/GUARDIANSHIP**:** If a conservatorship/guardianship of my person needs to be appointed for me by a court, I nominate the agent designated in this form.

AFTER-DEATH WISHES:

Initial those that apply.

Organ and tissue donation:
_______I wish to donate any and all of my organs and tissues.
_______I wish to donate only the organs or tissues listed here:
____
____

Autopsy:
______ My Agent is authorized to allow or request an autopsy.

Disposition of Remains:
______ My Agent is authorized to direct the disposition of my remains.
______ I have left specific after-death instructions which may be found at or in:
____
____

SIGNATURE:

Date: _____________ 20____

Sign here____

Print your name here____

(In order for this form to be complete and effective, your signature must be notarized or witnessed (usually by two persons), as required by the laws of the state in which you reside. For more information, see Finalization.)