EXPLANATION

You have the right to give instructions about your own health-care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a **power of attorney for health care**. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator or employee of a residential long-term health-care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

A) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;

B) Select or discharge health-care providers and institutions;

C) Approve or disapprove diagnostic tests, surgical procedures, programs of medication, and orders not to resuscitate; and

D) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care, including life-sustaining treatment.

EXPLANATION (CONTINUED)

Part 2 of this form lets you give specific **instructions** about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

Part 5 contains the signature and witnessing provisions so that your document will be effective.

After completing this form, sign and date the form at the end. You must have 2 other individuals sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

PART 1

Part 1: POWER OF ATTORNEY FOR HEALTH CARE

PRINT YOUR NAME

(1) **DESIGNATION OF AGENT**:
I, _____ designate the following person as my agent to make health care decisions for me:

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR PRIMARY AGENT

_____
(name of agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR FIRST ALTERNATIVE AGENT

If I revoke the authority of my agent or if my agent is not willing, able, or reasonably available to make health care decisions for me, I designate as my alternate agent:

_____
(name of first alternative agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBERS OF YOUR SECOND ALTERNATIVE AGENT

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health care decision for me, I designate as my second alternate:

_____
(name of second alternative agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone)

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

(2) **AGENT'S AUTHORITY**: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, **except** as I state here:

_____

_____

_____

_____

_____

_____

_____

CROSS OUT AND INITIAL ANY STATEMENTS WITHIN THE FOLLOWING PARAGRAPHS THAT DO NOT REFLECT YOUR WISHES

(3) **AGENT'S OBLIGATION**: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

INITIAL THE BOX IN PARAGRAPH (4) ONLY IF YOU WANT YOUR AGENT'S AUTHORITY TO TAKE EFFECT IMMEDIATELY

(4) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE**: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health-care decisions for me takes effect immediately.

(5) **NOMINATION OF GUARDIAN**: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2

Part 2: INSTRUCTIONS FOR HEALTH CARE

(6) **END-OF-LIFE DECISIONS**: I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

INITIAL THE PARAGRAPH THAT BEST REFLECTS YOUR WISHES REGARDING LIFE-SUPPORT MEASURES (INITIAL ONLY ONE)

____I Choose NOT To Prolong Life: I do not want my life to be prolonged if (i) I have an incurable or irreversible condition that will result in my death within a relatively short time; (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness; or (iii) the likely risks and burdens of treatment would outweigh the expected benefits;

OR

____I Choose To Prolong Life: I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(7) **ARTIFICIAL NUTRITION AND HYDRATION**: I also specify that under the conditions mentioned in the above paragraph:

INITIAL YOUR PREFERENCE REGARDING ARTIFICIAL NUTRITION AND HYDRATION (INITIAL ONLY ONE)

____ I **do not** want artificial nutrition and hydration provided to me in order to prolong my life.

____ I **do** want artificial nutrition and hydration provided to me in order to prolong my life.

(8) **RELIEF FROM PAIN OR DISCOMFORT**: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT PAIN RELIEF OR COMFORT CARE

_____

_____

_____

_____

(Add additional pages, if needed.)

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

(9) **OTHER HEALTH CARE INSTRUCTIONS OR WISHES**:

(Add additional pages, if needed.)

PART 3

ORGAN DONATION (OPTIONAL)

INITIAL THE STATEMENT THAT AGREES WITH YOUR WISHES ABOUT ORGAN DONATION (INITIAL ONLY ONE)

STRIKE THROUGH ANY USES YOU DO NOT AGREE TO

Part 3: DONATION OF ORGANS AT DEATH

(10) Upon my death: (initial applicable box)

____ (a) I do not give any of my organs, tissues, or parts and do not want my agent, conservator, or family to make a donation on my behalf,

____ (b) I give any needed organs, tissues, or parts,

OR

____ (c) I give the following organs, tissues, or parts only:

_____

_____

_____

My gift is for the following purposes:
(strike any of the following you do not want)

(1) Transplant

(2) Therapy

(3) Research

(4) Education

PART 4

DESIGNATION OF PRIMARY PHYSICIAN (OPTIONAL)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR ALTERNATE PRIMARY PHYSICIAN

Part 4: DESIGNATION OF PRIMARY PHYSICIAN

(11) I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

If the physician I have designated is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address)

_____
(city) (state) (zip code)

_____
(phone)

PART 5

Part 5: EXECUTION

Sign and date the form here:

SIGN YOUR DOCUMENT PRINT THE DATE, YOUR NAME, AND YOUR ADDRESS

_____
(signature) (date)

_____
(name)

_____
(address)

WITNESSES

Witness 1:

HAVE YOUR TWO WITNESSES SIGN AND DATE THE DOCUMENT, AND THEN PRINT THEIR NAMES AND ADDRESSES

_____
(signature) (date)

_____
(name)

_____
(address)

Witness 2:

_____
(signature) (date)

_____
(name)

_____
(address)

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898