ADVANCE DIRECTIVE

PRINT YOUR NAME, DATE OF BIRTH, DATE, ADDRESS, TELEPHONE NUMBER, AND EMAIL ADDRESS

My Name _____ Date of Birth _____

Date signed _____

Address _____ City _____ Zip _____

Phone _____ Email _____

PART 1 – APPOINTMENT OF AN AGENT

1. I want my agent to make decisions for me: (choose one statement below)

INITIAL ONLY ONE

_____ when I am no longer able to make health care decisions for myself, or

_____ immediately, allowing my agent to make decisions for me right now, or

_____ when the following condition or event occurs (to be determined as follows):

_____

_____

PRINT THE NAME OF YOUR AGENT

2. I appoint _____ as my health care Agent to make any and all health care decisions for me, except to the extent that I state otherwise in this Advance Directive. (You may cross out the italicized phrase if authority is unrestricted.)

PRINT ADDRESS, RELATIONSHIP, DAY TELEPHONE NUMBERS, AND EMAIL ADDRESS OF YOUR AGENT

Address _____ Relationship (optional) _____

_____

Tel. (daytime) _____ cell phone _____

(evening) _____ email _____

PRINT THE NAME OF YOUR ALTERNATE AGENT

PRINT ADDRESS, RELATIONSHIP, TELEPHONE NUMBERS, AND EMAIL ADDRESS OF YOUR ALTERNATE AGENT

PRINT THE NAME OF YOUR SECOND ALTERNATE AGENT

PRINT ADDRESS, RELATIONSHIP, TELEPHONE NUMBERS AND EMAIL ADDRESS OF YOUR NEXT ALTERNATE AGENT

PRINT ADDITIONAL INSTRUCTIONS, IF ANY, FOR YOUR AGENT HERE

ATTACH ADDITIONAL PAGES IF NEEDED

3. If this health care agent is unavailable, unable or unwilling to do this for me, I appoint _____ to be my Alternate Agent.

Address _____Relationship (optional) _____

Tel. (daytime) _____cell phone _____

(evening) _____email _____

And if my Alternate Agent is unavailable, unable or unwilling to do this, I appoint _____ as my Next Alternate Agent.

Address _____ Relationship (optional) _____

Tel. (daytime) _____cell phone _____

(evening) _____ email _____

4. General guidance for my agent: When making health care decisions for me, my agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in this or any other document, my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my agent should make decisions for me that my agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

5. I give the following further instructions, if any, for my agent's guidance:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(attach additional pages if needed)

PART 2 – OTHERS WHO MAY BE INVOLVED IN MY CARE

PRINT YOUR DOCTOR'S OR CLINICIAN'S NAME, ADDRESS AND PHONE NUMBER

1. My Doctor or other Health Care Clinician:

Name _____ Phone _____

Address _____

OR

Name _____ Phone _____

Address _____

LIST PEOPLE WHO MAY BE CONSULTED ABOUT YOUR HEALTH CARE DECISIONS

2. Other people whom my agent MAY consult about medical decisions on my behalf;

_____

_____

LIST PEOPLE WHO SHOULD NOT BE CONSULTED ABOUT YOUR HEALTH CARE DECISIONS

Those who should NOT be consulted by my agent include:

_____

LIST PEOPLE YOU WANT TO HAVE INFORMATION ABOUT YOUR CONDITION

3. My health agent or health care provider may give information about my condition to the following adults and minors:

_____

_____

LIST PEOPLE YOU DON'T WANT TO BE ABLE TO CHALLENGE YOUR AGENT OR CLINICIAN IN COURT REGARDING THE INSTRUCTIONS AND/OR APPOINTMENTS IN THIS DOCUMENT

4. The person(s) named below shall NOT be entitled to bring a court action on my behalf concerning matters covered by this advance directive, nor serve as a health care decision maker for me.

_____
_____
_____
_____
_____
_____
_____
_____

(attach additional pages if needed)

INITIAL TO INDICATE WHO YOU WANT NOMINATED AS YOUR GUARDIAN, IN THE EVENT A COURT DECIDES THAT YOU NEED ONE

5. If I need a guardian in the future, I ask the court to consider appointing the following person:

_____ My health care agent

_____ The following person:

Name _____ Phone _____

Address _____

You may also list alternative preferred guardians, or persons that you would not want to have appointed as guardians.

LIST ALTERNATE GUARDIANS, IF ANY

Alternate preferred guardians:_____

LIST PEOPLE YOU DON'T WANT NOMINATED AS YOUR GUARDIAN

Persons I would not want to be my guardian: _____

_____

PART 3 – STATEMENT OF VALUES AND GOALS

STATE IN YOUR OWN WORDS WHAT IS MOST IMORTANT TO YOU REGARDING YOUR HEALTH CARE

Use the space below to state in your own words what is most important to you.

STATE GENERAL ADVICE ABOUT HOW TO APPROACH YOUR HEALTH CARE CHOICES

General advice about how to approach health care choices depending upon your current or future state of health or the chances of success of various treatments.

STATE OTHER VALUES AND GOALS TO HELP GUIDE HEALTH CARE DECISIONS MADE ON YOUR BEHALF

Other statement of values and goals to help guide health care decisions made on your behalf.

PART 4 – END-OF-LIFE WISHES

If the time comes when I am close to death or am unconscious and unlikely to become conscious again (initial all that apply):

INITIAL ONLY ONE OF CHOICES 1-3

1. _____ I **do** want all possible treatments to extend my life.

   - or -

2. _____ I **do not** want my life extended by any of the following means:

   _____ breathing machines (ventilator or respirator)

   _____tube feeding (feeding and hydration by medical means)

   _____ antibiotics

   _____ other medications whose purpose is to extend my life

   _____ any other means

   _____ Other (specify) _____

INITIAL ALL THAT APPLY TO YOU OF CHOICES 4-7

3. _____ I want my **agent to decide** what treatments I receive, including tube feeding.

4. _____ I want care that preserves my dignity and that provides **comfort and relief** from symptoms that are bothering me.

5. _____ I want **pain medication** to be administered to me even though this may have the unintended effect of hastening my death.

6. _____ I want **hospice** care when it is appropriate in any setting.

7. _____ I would prefer to **die at home** if this is possible.

ADD OTHER WISHES AND INSTRUCTIONS, IF ANY

8. Other wishes and instructions: (state below or use additional pages):

_____

_____

_____

_____

_____

PART 5 – OTHER TREATMENT WISHES

INITIAL ALL THAT APPLY TO YOU

1. _____I wish to have a **Do Not Resuscitate (DNR) Order** written for me.

2. _____ If I am in a critical health crisis that may not be life-ending and more time is needed to determine if I can get better, I want treatment started. If, after a reasonable period of time, it becomes clear that I will not get better, I want all life extending treatment stopped. This includes the use of breathing machines or tube feeding.

3. If I am conscious but become unable to think or act for myself and will likely not improve, I do not want the following life-extending treatment:
   - _____ breathing machines (ventilators or respirators)
   - _____ feeding tubes (feeding and hydration by medical means)
   - _____ antibiotics
   - _____ other medications whose purpose is to extend life
   - _____ other treatment to extend my life
   - _____ other _____

4. _____ If the likely cost, risks and burdens of treatment are more than I wish to endure, I do not want life-extending treatment. The costs, risks and burdens that concern me the most are: _____

   _____

5. _____ If it is determined that I am pregnant at the time this Advance Directive becomes effective, I want:
   - _____ all life sustaining treatment, (or)
   - _____ only the following life sustaining treatments:
     - _____ breathing machines (ventilators or respirators)
     - _____ feeding tubes (feeding and hydration by medical means)
     - _____ antibiotics
     - _____ other medications whose purpose is to extend life
     - _____ any other treatment to extend my life
   - _____ other _____
   - _____ no life sustaining treatment.

LIST HOSPITALS OR TREATMENT FACILITIES NAME, ADDRESS AND PHONE NUMBERS

6. **Hospitalization** – If I need care in a hospital or treatment facility, the following facilities are listed in order of preference:

Hospital/Facility _____ Address _____
Tel. # _____

Hospital/Facility _____ Address _____
Tel. # _____

LIST HOSPITALS OR TREATMENT FACILITIES YOU WANT TO AVOID, AND REASON

I would like to avoid being treated in **the following facilities:**

Hospital/Facility _____

Hospital/Facility _____

LIST MEDICATIONS OR TREATMENTS YOU WOULD LIKE TO RECEIVE

7. **I prefer the following medications or treatments:** Use more space or additional sheets for this section, if needed.

_____

LIST MEDICATIONS OR TREATMENTS YOU WOULD LIKE TO AVOID AND REASONS

Avoid **use of the following medications or treatments:**

List medications/treatments:

_____

_____

INTIAL AND CIRCLE THE ONE THAT APPLIES TO YOU

8. **Consent for Student Education, Treatment Studies, or Drug Trials**

_____**I do / do not** (circle one) wish to participate in student medical education.

_____**I do / do not** (circle one) wish to participate in treatment studies or drug trials.

(or)

_____ I authorize **my agent to consent** to any of the above.

PART 6 – ORGAN AND TISSUE DONATION

I want my agent (if I have appointed one) and all who care about me to follow my wishes about organ donation if that is an option at the time of my death. (Initial below all that apply.)

INITIAL ONLY ONE

_____**I do <u>not</u> wish to be an organ donor.**

_____**I wish to donate the following organs and tissues:**

INITIAL YOUR ORGAN DONATION CHOICES

_____ any needed organs or tissues
_____major organs (heart, lungs, kidneys, etc.)
_____tissues such as skin and bones
_____eye tissue such as corneas

Agent for organ donation (optional)

YOU MAY CHOOSE SOMEONE TO MAKE ORGAN DONATION DECISIONS FOR YOU

_____ I wish my agent to make any decisions for anatomical gifts

OR

_____ I wish the following person(s) to make any decisions:

_____

_____

INITIAL HERE IF YOU WANT TO DONATE YOUR BODY TO SCIENCE

_____**I desire to donate my body to research or educational programs.**

(Note: you will have to make your own arrangements through a Medical School or other program.)

PART 7 – DISPOSITION OF MY BODY AFTER DEATH

1. **My Directions for Burial or Disposition of My Remains after Death.**

INITIAL ONLY ONE

_____I want a funeral followed by burial in a casket at the following location, if possible (please tell us where the burial plot is located and whether it has been pre-purchased): _____ (or)
_____ I want to be cremated and want my ashes buried or distributed as follows:

_____ (or)

____ I want to have arrangements made at the direction of my agent or family.

Other instructions: _____
(for example, you may include contact information for Medical School programs if you have made arrangements to donate your body for research or education.)

2. Agent for disposition of my body (select one)**:**

INITIAL ONLY ONE

_____ I want my health care agent to decide arrangements after my death.
If he or she is not available, I want my alternate agent to decide.
_____ I appoint the following person to decide about and arrange for the disposition of my body after my death:

PRINT NAME, ADDRESS, TELEPHONE NUMBERS, AND EMAIL ADDRESS OF THE PERSON YOU WANT TO DECIDE ARRANGEMENTS AFTER YOUR DEATH

Name _____ Address _____

Telephone _____ Cell phone _____ Email _____

(or)

_____ I want my family to decide.

3. If an autopsy is suggested following my death:

INITIAL ONLY ONE

_____ I support having an autopsy performed.
_____ I would like my agent or family to decide whether to have it done.

4. I have already made funeral or cremation arrangements with:

PRINT NAME, ADDRESS, AND TELEPHONE NUMBER OF THE PERSON YOU MADE FUNERAL OR CREMATION ARRANGEMENTNTS WITH

Name _____ Tel. _____

Address _____

PART 8 – OTHER INSTRUCTIONS

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

I give the following instructions:

(attach additional pages if needed)

PART 9 – SIGNATURE AND WITNESSES

PRINT YOUR NAME, DATE OF BIRTH, AND TODAY'S DATE

My Name _____DOB _____ Date _____

I declare that this document reflects my desires regarding my future health care, (organ and tissue donation and disposition of my body after death, and that I am signing this advance directive of my own free will.

SIGN AND DATE

Signed _____ Date _____

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES HERE

Acknowledgement of Witnesses

I affirm that the Principal appears to understand the nature of an Advance Directive and to be free from duress or undue influence.

Signed _____ Date _____

Print Name _____

Signed _____ Date _____

Print Name _____

Acknowledgement by the person who explained the Advance Directive if the principal is a current patient or resident in a hospital, or other health care facility.

IF YOU ARE IN A HOSPITAL, NURSING HOME, OR RESIDENTIAL CARE FACILITY, A THIRD PERSON MUST SIGN, DATE, AND PRINT HIS/HER NAME, ADDRESS, TITLE, AND TELEPHONE NUMBER

I affirm that:

- The maker of this Advance Directive is a current patient or resident in a hospital, nursing home or residential care facility,
- I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in Vermont, or a probate division of the superior court designee or hospital designee, and
- I have explained the nature and effect of the Advance Directive to the Principal and it appears that the Principal is willingly and voluntarily executing it.

Signature_____Date _____

Name _____

Address _____

Title/position _____ Tel. _____

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