Advance Directives
Making your Wishes Known

It is vital for your health care providers and family to know what is most important to you so we can honor your wishes. Advance Directives guide others to make medical care decisions you would make for yourself if you are unable to speak for yourself. This packet provides general information and Advance Directive forms to complete, which includes a Health Care Surrogate Designation form and a Living Will.

What do I do after completing my Advance Directive form?

- It is very important that you discuss your wishes and medical care with your Health Care Surrogate, family, and health care providers so they can honor your wishes.
- Share copies of this form with your Health Care Surrogate, doctors, nurses, caregivers, family, and friends as appropriate.
- Keep a copy for yourself that someone can easily find.
- Consider reviewing your forms every few years and during any major health event because your wishes may change.

What if I change my mind?

- You can change your mind at any time.
- Your spoken wishes about medical treatment must be honored even if different from your forms.
- If your wishes change it is best to fill out a new form and update your Health Care Surrogate and medical team.

Please talk to your physician, clergy, or attorney if you have further questions.

The Health Care Surrogate is a person you trust and name to make medical decisions when you are too sick to make your own decisions or are able to make decision but would like your surrogate to make medical decisions on your behalf. Your Health Care Surrogate should make decisions guided by your Living Will. In some situations, your Health Care Surrogate will be asked to make decisions based on your best interest. Often family members are good choices, but not always.

When you choose a Health Care Surrogate consider:

- Someone who is 18 years of age or over and is mentally competent to make decisions.
- Someone who understands your personal, social, and spiritual values and will advocate for you.
- Someone who will honor and advocate for your wishes even if they are different from their own.
- Someone who will be available and can work well with the medical team.
- Someone who can handle stressful family situations.

What if I do not choose a Health Care Surrogate?

If you are too sick to make your own decisions and you do not name a Health Care Surrogate, your Next of Kin will be your decision maker which would include the following, in the highest order of priority:

1. Spouse
2. Adult children
3. Parent(s)
4. Adult sibling(s)
5. Adult relative(s)
6. Close personal friend (by notarized affidavit)

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Designation of Health Care Surrogate Form

In the event that I, (full name) _____, am no longer able to make my own health care decisions, I choose as **my Health Care Surrogate**:

Name: _____/_____ _____
First Name Last Name Phone #

Address: _____

If my Health Care Surrogate is unwilling or unable to perform these duties, I choose as **my alternative Health Care Surrogate**:

Name: _____/_____ _____
First Name Last Name Phone #

Address: _____

My Health Care Surrogate's authority becomes effective when my physician(s) determine that I am unable to make my own health care decisions.

Optional: I also have the option to choose that my Health Care Surrogate's authority become **effective immediately** even while I am competent by initialing either or both of the following boxes:

I MUST initial:

_____ My Health Care Surrogate has authority to receive my health information while I'm competent.
Initial

_____ My Health Care Surrogate has authority to make health decisions for me even while I am competent. However, any instructions or health care decisions I make, either verbally or in writing, will supersede any instructions or health care decisions made by my Health Care Surrogate while I have the capacity to do so.
Initial

Specific instructions or restrictions:_____

I authorize my health care surrogate to make all health care decisions for me, which means he or she has the authority to:

- Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
- Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
- Apply on my behalf for private, public, government, or veterans' benefits to defray the cost of health care.
- Decide to make an anatomical gift.

My Signature:_____ Date:____/____/____ Time**:** _____

_____ _____
1st Witness (required): **2nd Witness (required)**:

Witness Signatures: Two required. Your Health Care Surrogate **cannot** be a witness. Only one witness can be your family or spouse. You do not need a notary.

☐ Phone
_____ OR ☐ Video _____ _____ _____
Qualified Staff / Interpreter Signature (Check) Print Qualified Staff / Interpreter Name ID Number Language Interpreted

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LIVING WILL INFORMATION

The Living Will lets your health care team, family and others know your wishes regarding life support treatment and how to apply them to your medical care. Life support treatments are used when you are very sick. These treatments are often helpful, but in certain situations can only add to suffering and prolong the dying process. The difference between prolonging life and prolonging suffering depends on your values about what makes life worth living. Often when you are so sick that you may die soon you are unable to speak for yourself. This part helps you keep a 'voice' in your care when you are not able to speak.

Life support treatments may include, but are not limited to, **medicines, surgeries, invasive procedures**, such as:

- **Intubation with a breathing machine or ventilation**: when a tube is placed through your mouth to your lungs, or a tracheostomy tube in your neck, so that a machine can pump air into your lungs and breathe for you.
- **Artificial feeding:** this would include a feeding tube or TPN (IV nutritional support) if you cannot swallow.
- **IV Fluids**: for hydration and administration of medications
- **Blood transfusions**: to put other blood or blood products into your veins
- **Dialysis**: a machine that cleans your blood if your kidneys stop working

LIVING WILL FORM

My wish is if I am very sick: (Initial EITHER Section I or II below)

Section I. I do not want any life support treatment if I am in a: (initial all that apply)

_____ *Initial* **Persistent Vegetative State**: a permanent condition of unconsciousness, meaning you cannot interact with the world and have no voluntary actions or thinking behavior.

_____ *Initial* **End Stage Condition**: an irreversible condition that causes severe worsening and permanent decrease in health where treatment would not likely work.

_____ *Initial* **Terminal Condition**: a condition where there is likely no probability of recovery and it is expected to cause death without treatment.

I do _____ (*initial*) or I do not _____ (*initial*) want to be given nutrition and / or hydration artificially by a feeding tube or by intravenous feedings when it would serve only to prolong artificially the process of dying.

I willfully and voluntarily make known my desire that my dying not be artificially prolonged under the above initialed circumstances. I request to be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain

OR

Section II.

_____ *Initial* I do want to try the life support treatments my physician thinks might help. If the treatments do not work and there is little hope of getting better, I do not want to stay on life support machines.

Additional Instructions (Optional): _____

I request that my Living Will be honored by my family and medical team and I accept the consequences of my choices. I am thinking clearly.

My Signature:_____ Date:_____/_____/_____ Time: _____

_____ _____

1st Witness (required): 2nd Witness (required):

Witness Signatures: Two required. Only one witness can be your family or spouse. You do not need a notary.

☐ Phone

_____ OR ☐ Video _____ _____ _____

Qualified Staff / Interpreter Signature (Check) Print Qualified Staff / Interpreter Name ID Number Language Interpreted

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Advance Directive Forms
Tab: Legal Forms and Consents DH: Advance Directive/Living Will - AH Form
602-0177 (12/17) MPC 15398

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ADDITIONAL IMPORTANT INFORMATION REGARDING YOUR WISHES TO SHARE WITH YOUR HEALTH CARE TEAM AND HEALTH CARE SURROGATE / FAMILY

A Living Will is NOT a "Do Not Resuscitate" (DNR) order.

If you do not want CardiopuImonary Resuscitation (CPR) in the event you have a cardiac or respiratory arrest, you will need to speak to your physician to order a "Do Not Resuscitate" (DNR) (Allow Natural Death) order. A specific "DNR order" is required which tells the medical team how to treat you in the event your heart and / or lungs stop working. It does not mean "Do Not Treat" before your heart/lungs stopped. If you are a patient, you will receive care and treatment recommended by your physician and agreed upon by you. Please talk with your health care provider about your current medical condition as well as the benefit and harm of each treatment option.

Cardiopulmonary Resuscitation (CPR) is an attempt to resume your heart and lung function if your heart or lungs stop working. CPR may include:

- Chest compressions – pressing in a hard-repetitive motion on your chest to attempt to keep your blood flowing
- Defibrillation - Electric shocks to attempt to restart your heart
- Medicines in your veins
- Intubation with a breathing machine or ventilation

If CPR is successful, you usually would be in the Intensive Care Unit on a breathing machine and other treatment therapies, if needed.

If you decide you do not want CPR measures taken in the event of a cardiac and/or respiratory arrest, you (or your health care surrogate or next of kin on your behalf if you are unable to make medical decisions) will need to sign a separate "Do Not Resuscitate" (DNR) Order form. There are two types of DNR forms, hospital specific and community. Your health care provider can provide you more information regarding the most appropriate DNR order form for use based on your wishes.

If you are a patient in the hospital, speak with your physician regarding having a Do Not Resuscitate Order form completed.

If you are in the community, you may download and print the State of Florida Do Not Resuscitate Order form. You may access the form at http://www.floridahealth.gov/about-the-department-of-health/about-us/patient-rights-and-safety/do-not-resuscitate/index.html. This form must be printed on yellow paper and signed by yourself and your physician to be honored by the community Emergency Medical Services.

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