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ADVANCED DIRECTIVES

Things can change quickly, and it is good to be prepared. This Advanced Directives document gives you a way to ensure your wishes are known and followed when you are unable to make decisions on your own.

It is an easy-to-complete form that lets you say exactly what you want. Once it is filled out and properly signed, it is valid under the laws of most states.

Why is this important?

Doctors and health care professionals will listen to your wishes no matter how you express them.

Who should use an Advance Directive?

Advanced Directives is for anyone 18 or older – married, single, widowed, parents, adult children, and friends.

How do you use it?

Advanced Directives help express everything a person wants by providing a helpful guide to family members, friends, care givers, and doctors.

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DIRECTIVE 1: YOUR HEALTH CARE REPRESENTATIVE

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Picking The Right Person To Be Your Health Care Representative

Choose someone who knows you very well, cares about you, and who can make difficult decisions. Choose who you think would be the best at carrying out your wishes. A family member or spouse may not be the best choice because they may be too emotionally involved. Choose someone who is able to stand up for you so that your wishes are followed. Also, choose someone who is likely to be nearby so they can help when you need them. Whether you choose a spouse, family member, or friend as your Health Care Representative, make sure you talk about these directives and be sure that this person agrees to respect and follow your wishes. Your Health Care Representative should be at least 18 years or older (in Colorado, 21 years or older) and should **not** be:

- Your health care provider, including the owner or operator of a health or residential or community care facility serving you
- An employee or spouse of an employee of your health care provider
- Serving as an agent or proxy for 10 or more people unless he or she is your spouse or close relative

This document differs from a Power of Attorney (POA). Each state may have different requirements. Refer to your state's Attorney General or consult with your legal counsel.

My Health Care Representative

If I am no longer able to make my own health care decisions, this form designates the person I choose to make these decisions for me. This person will be my Health Care Representative (or other term that may be used in my state, such as proxy, agent, or surrogate). This person will make my health care decisions if both of these things happen.

- Your health care provider, including the owner or operator of a health or residential or community care facility serving you
- An employee or spouse of an employee of your health care provide **AND**
- Serving as an agent or proxy for 10 or more people unless he or she is your spouse or close relative

If my state has a different way of identifying that I am not able to make care decisions, then my state's way should be followed.

The Person I Choose As My Health Care Representative Is:

First Choice Name _____ Phone Number _____

Address _____ City/State/Zip _____

If this person is not able or willing to make these decisions for me, OR is divorced or legally separated from me, OR this person has died, then these people are my next choice.

Second Choice Name _____ Phone Number _____

Address _____ City/State/Zip _____

Third Choice Name _____ Phone Number _____

Address _____ City/State/Zip _____

DIRECTIVE 1: YOUR HEALTH CARE REPRESENTATIVE

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I understand that my Health Care Representative can make health care decisions for me. I want my Representative to be able to do the following: ***(Please check Yes or No for anything you do or do not want your Representative to do that is listed below.)***

YES	NO	
☐	☐	Make decisions for me about my medical care or services, like tests, medicine, or surgery. This care or service could be to find out what my health problem is, or how to treat it. It can also include care to keep me alive. If the treatment or care has already started, my Health Care Representative can keep it going or have it stopped.
☐	☐	Interpret any instructions I have given in this form or given in other discussions, according to my Health Care Representative's understanding of my wishes and values.
☐	☐	Consent to admission to an assisted living facility, hospital, hospice, or nursing home for me. My Health Care Representative can hire any kind of health care workers I may need to help me or take care of me. My Representative may also fire a health care worker, if needed.
☐	☐	Make the decision to request, take away, or not give medical treatments, including artificially-provided food and water, and any other treatments to keep me alive.
☐	☐	See and approve release of my medical records and personal files. If I need to sign my name to get any of these files, my Health Care Representative can sign it for me.
☐	☐	Move me to another state to get the care I need or to carry out my directives.
☐	☐	Authorize or refuse to authorize any medication or procedure needed to help with pain.
☐	☐	Take any legal action needed to carry out my directives.
☐	☐	Donate useable organs or tissues of mine as allowed by law.
☐	☐	Apply for Medicare, Medicaid, or other programs or insurance benefits for me. My Health Care Representative can see my personal files, like bank records to find out what is needed to fill out these forms.

Listed below are any changes, additions, or limitations on my Health Care Representative's powers.

If I Change My Mind About Having A Health Care Representative, I Will

- Destroy all copies of this part of the Advanced Directives form **OR**
- Tell someone, such as my doctor or family, that I want to cancel or change my Health Care Representative **OR**
- Write the word "Revoked" in large letters across the name of each agent whose authority I want to cancel and sign my name and date.

DIRECTIVE 2: MEDICAL TREATMENT

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What You Should Keep In Mind As My Caregiver

- I do not want to be in pain. I want to be comfortable. Directive 3 indicates what can be done to make me comfortable.
- I want to be offered food and fluids by mouth if it is safe for me to eat and drink.
- I want to be kept clean and warm.
- I do not want anything done or omitted by my doctors or nurses with the intention of taking my life.

Here is the kind of medical treatment that I want or don't want in the four situations listed below. I want my Health Care Representative, my family, my doctors and other health care providers, my friends, and all others to know these directions.

Close To Death:

If my doctor and another health care professional both decide that I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death (choose one of the following): what I want and under what conditions.

- ☐ I want to have life-support treatment.
- ☐ I do not want life-support treatment. If it has been started, I want it stopped.
- ☐ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms

In a Coma And Not Expected To Wake Up Or Recover:

If my doctor and another health care professional both decide that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life-support treatment would only delay the moment of my death (choose one of the following):

- ☐ I want to have life-support treatment.
- ☐ I do not want life-support treatment. If it has been started, I want it stopped.
- ☐ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

Permanent And Severe Brain Damage And Not Expected To Recover:

If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example, I can open my eyes, but I can not speak or understand) and I am not expected to get better, and life-support treatment would only delay the moment of my death (choose one of the following):

- ☐ I want to have life-support treatment.
- ☐ I do not want life-support treatment. If it has been started, I want it stopped.
- ☐ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

What "Life-Support Treatment" Means to Me

Life-support treatment means any medical procedure, device, or medication to keep me alive. Life-support treatment includes: medical devices put in me to help me breathe; food and water supplied by medial device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive. If I wish to limit the meaning of life-support treatment because of my religious or personal beliefs, I write this limitation in the space below. I do this to make very clear what I want and under what conditions.

My Directive For How Comfortable I Want to Be.

*(Please indicate **'NO'** for anything that you don't agree with.)*

YES	NO	
☐	☐	I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means I will be drowsy or sleep more than I would otherwise.
☐	☐	If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my care givers to do whatever they can to help me.
☐	☐	I wish to have a cool moist cloth put on my head if I have a fever.
☐	☐	I want my lips and mouth kept moist to stop dryness.
☐	☐	I wish to have warm baths often. I wish to be kept fresh and clean at all times.
☐	☐	I wish to be massaged with warm oils as often as I can be.
☐	☐	If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.
☐	☐	I wish to have personal care like shaving, nail clipping, hair brushing, and teeth brushing, as long as they do not cause me pain or discomfort.
☐	☐	I wish to have religious or spiritual readings and well-loved poems read aloud when I am near death.
☐	☐	I wish to know about options for hospice care to provide medical, emotional, and spiritual care for me and my loved ones.

DIRECTIVE 4: HOW I WANT TO BE TREATED

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My Wish For How I Want People to Treat Me

*(Please indicate **'NO'** for anything that you don't agree with.)*

YES	NO	
☐	☐	I wish to have people with me when possible.
☐	☐	I want someone to be with me when it seems that death may come at any time.
☐	☐	I wish to have my hand held and to be talked to when possible, even if I don't seem to respond to the voice or touch of others.
☐	☐	I wish to have others by my side praying for me when possible.
☐	☐	I wish to have the members of my faith community told that I am sick and asked to pray for me and visit me.
☐	☐	I wish to be visited by a chaplain or clergy.
☐	☐	I wish to be cared for the kindness and cheerfulness, and not sadness.
☐	☐	I wish to have pictures of my love ones in my room, near my bed.
☐	☐	I wish to have my favorite music played when possible until my time of death.
☐	☐	I want to die in my home, if that can be done.
☐	☐	I wish to be called by my name. Please call me: _____

My Wish For What I Want My Loved Ones to Know.

*(Please indicate **'NO'** for anything that you don't agree with.)*

YES	NO	
☐	☐	I wish to have my family and friends know that I love them.
☐	☐	I wish to be forgiven for the times I have hurt my family, friends, and others.
☐	☐	I wish to have my family, friends, and others know that I forgive them for when they may have hurt me in my life.
☐	☐	I wish for my family and friends to know that I do not fear death. I think it is not the end, but a new beginning for me.
☐	☐	I wish for all of my family members to make peace with each other before my death, if they can.
☐	☐	I wish for my family and friends to think about what I was like before I became seriously ill. I want them to remember me in this way after my death.
☐	☐	I wish for my family and friends and caregivers to respect my wishes even if they don't agree with them.
☐	☐	I wish for my family and friends to look at my dying as a time of personal growth for everyone, including me. This will help me live a meaningful life in my final days.
☐	☐	I wish for my family and friends to get counseling if they have trouble with my death. I want memories of my life to give them joy and not sorrow.

DIRECTIVE 6: AFTER MY DEATH

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After my death I would like my body to be (**circle one**): buried OR cremated.

- My body or remains should be put in the following location:

  _____

- The following person knows my funeral wishes:

  _____

If anyone asks how I want to be remembered, please say the following about me:

_____

_____

_____

_____

_____

_____

If there is to be a memorial service for me, I wish for the service to include the following (list music, songs, readings, or other specific requests that you have):

_____

_____

_____

_____

_____

_____

DIRECTIVE 7: WHAT MATTERS TO ME

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It is important for my health care providers to know what matters most to me. I wish for them to know the following:

Please use the space below for any other wishes. For example, You may want to donate any or all organs of your body when your die. You may also wish to designate a charity to receiver memorial contributions. Or you may want to give instructions on what should be done with your social media or other electronic records. Please attach a separate sheet of paper if you need more space.

SIGNING MY DIRECTIVES

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Please make sure you sign your Advanced Directives in the presence of two witnesses.

I, _____, ask that my family, my doctors, other health care providers, my friends, and all others, follow my wishes as communicated by my Health Care Representative (if I have one and he or she is available), or as otherwise expressed in this form. This form becomes valid when I am unable to make decisions or speak for myself. If any part of this form cannot be legally followed, I ask that all other parts of this form be followed. I also revoke any Health Care Advance Directives I have made before.

_____ _____

Signature Address

_____ _____ _____

Phone Date City/State/Zip

Witness Statement (2 witnesses needed):

I, the witness, declare that the person who signed or acknowledged this form (hereafter "person") is personally known to me, that he/she signed or acknowledged this [Health Care Representative and/or Living Will form(s)] in my presence, and that he/she appears to be of sounds mind and under no duress, fraud, or undue influence.

- I also declare that I am over 18 years of age (in Colorado, 21 years or older) and am NOT: The individual appointed as (agent/proxy/surrogate/patient advocate/representative) by this document of his/her successor,
- This person's health care provider, including owner or operator of a health, long-term care, or other residential or community care facility serving the person,
- An employee of the person's health care provider,
- Financially responsible for the person's health care,
- An employee of a life or health insurance provider or the person,
- Related to the person by blood, marriage, or adoption,
- A beneficiary of any legal instrument, account, or benefit plan of the person, and
- To the best of my knowledge, a creditor of the person or entitled to any part of his/her estate under a will or codicil, by operation of law.

(Some states may have fewer rules about who may be a witness. Unless you know your state's rules, please follow the above).

_____ _____

Signature of Witness #1 Signature of Witness #2

_____ _____

Printed Name of Witness Printed Name of Witness

_____ _____

Address Address

_____ _____

Phone Phone

SIGNING MY DIRECTIVES

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Notarization

(Only required for residents of Missouri, North Carolina, South Carolina, and West Virginia)

If you live in Missouri, only your signature should be notarized. If you live in North Carolina, South Carolina, or West Virginia, you should have your signature, and the signatures of your witnesses notarized.

_____

On this _____ day of _____, 20_____, the said _____, and _____, known to me (or satisfactorily proven) to be the person named in the foregoing instrument and witnesses, respectively, personally appeared before me, a Notary Public, within and for the State and Country aforesaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

My Commission Expires: _____ Notary Public: _____

What To Do After You Complete Advanced Directives

- Talk about your wishes with your Health Care Representative, family members, and others who care about you. Give them copies of your completed Advanced Directives.
- Keep the original copy you signed in a special place in your home. DO NOT put it in a safe deposit box. Keep it nearby so that someone can find it when you need it.
- Talk to your doctor during your next office visit. Give your doctor a copy of your Advanced Directives. Make sure it Is put in your medical record. Be sure your doctor understands your wishes and is willing to follow them. Ask him or her to tell other doctors who treat you to honor them.

NOTES

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