**Pennsylvania Advance Health Care Directive**

**This form lets you have a say about how you want to be treated if you get very sick.**

**This form has 3 parts. It lets you:**

**Part 1: Choose a medical decision maker.**

**A medical decision maker is a person who can make health care decisions for you if you are too sick to make them yourself.**

**Part 2: Make your own health care choices.**

**This form lets you choose the kind of health care you want.**

**This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.**

**Part 3: Sign the form.**

**It must be signed before it can be used.**

**You can fill out Part 1, Part 2, or both.**

**Fill out only the parts you want. Always sign the form in Part 3. 2 witnesses need to sign on page 11.**

**YOUR NAME:**

**Pennsylvania Advance Health Care Directive**

**If you only want to name a medical decision maker go to Part 1 on page 3.**

**If you only want to make your own health care choices go to Part 2 on page 6.**

**If you want both then fill out Part 1 and Part 2.**

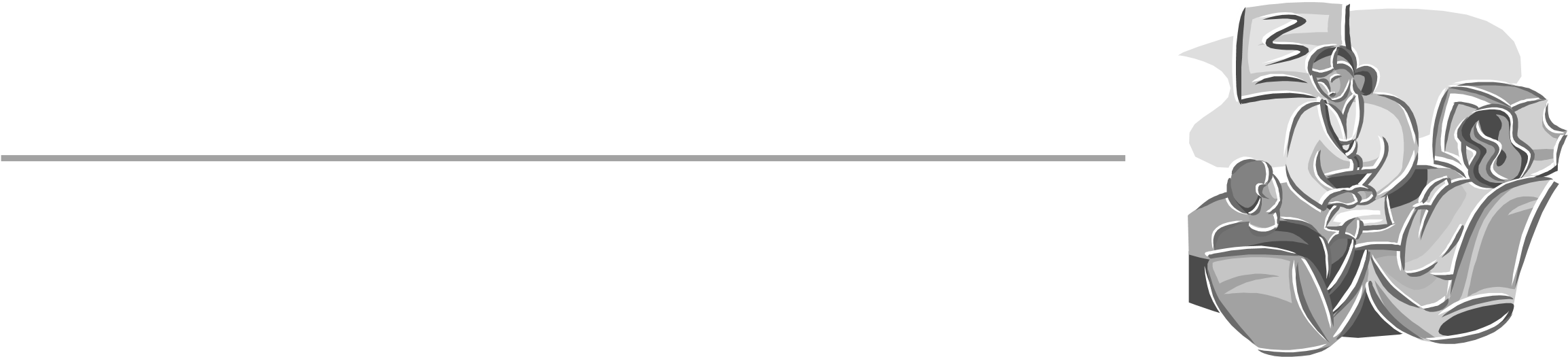
**Always sign the form in Part 3 on page 9. 2 witnesses need to sign on page 11.**

**What if I change my mind?**

s **Fill out a new form.** s **Tell those who care for you about your changes.**

s **Give the new form to your medical decision maker and doctor.**

**What if I have questions about the form?**

 **Ask your doctors, nurses, social workers, friends or family to answer your questions. Lawyers can help too.**

**What if I want to make health care choices that are not on this form?**

**Share this form and your choices with your family, friends, and medical providers.**



**Write your choices on page 9.**

**2**

**Pennsylvania Advance Health Care Directive**

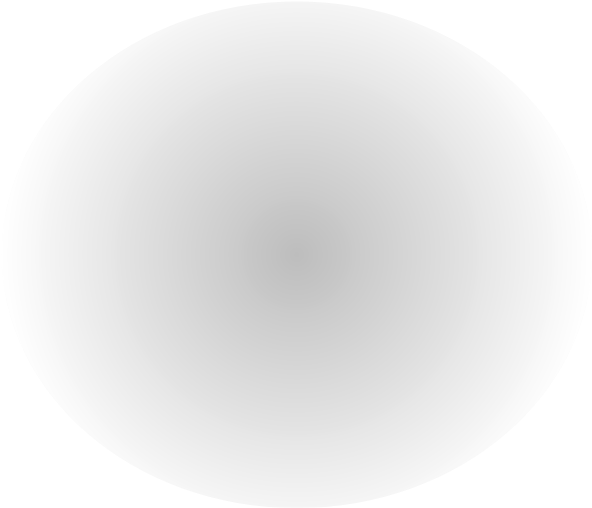
# Part 1 Choose your medical decision maker

**The person who can make health care decisions for you if you are too sick to make them yourself.**

**Whom should I choose to be my medical decision maker?**

**A family member or friend who:**

s **is at least 18 years old** s **knows you well**



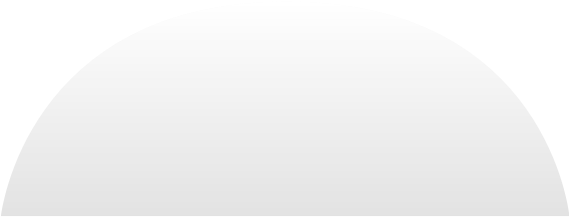
s **can be there for you when you need them** s **you trust to do what is best for you**

s **can tell your doctors about the decisions you made on this form**

**Y our decision maker cannot be your doctor or someone who works at your hospital or clinic, unless he/she is a family member.**

**What will happen if I do not choose a medical decision maker?**

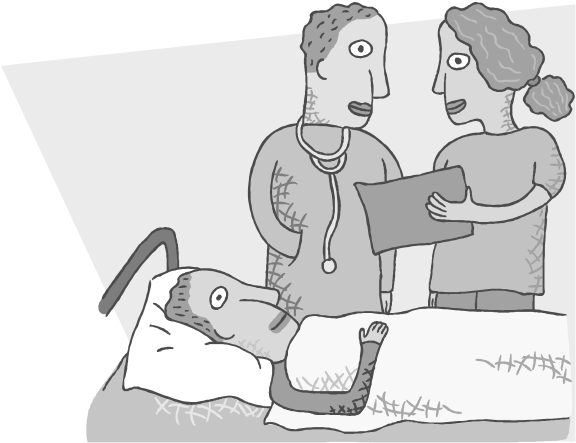
**If you are too sick to make your own decisions, a person**



**will be chosen for you according to Pennsylvania law. This person may not know what you want.**

**What kind of decisions can my medical decision maker make?**

**Agree to, say no to, change, stop or choose:** s **doctors, nurses, social workers** s **hospitals, clinics, or where you live** s **medications, tests, or treatments**

s **what happens to your body and organs after you die**

**Your decision maker will need to follow the health care choices you make in Part 2.**

|  |  |
| --- | --- |
| **Part 1: Choose your health care agent** | **Pennsylvania Advance Health Care Directive** |

**Other decisions your medical decision maker can make:**

**Life support treatments – medical care to try to help you live longer**

s **CPR or cardiopulmonary resuscitation**

**cardio = heart pulmonary = lungs resuscitation = to bring back**

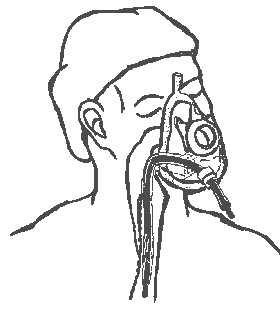
**This may involve:**

* + **pressing hard on your chest to keep your blood pumping**
  + **electrical shocks to jump start your heart**
  + **medicines in your veins**

s **Breathing machine or ventilator**

**The machine pumps air into your lungs and breathes for you.**

**You are not able to talk when you are on the machine.**



s **Dialysis**

**A machine that cleans your blood if your kidneys stop working.**

s **Feeding Tube**

**A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.**



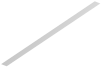
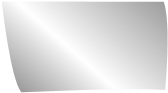
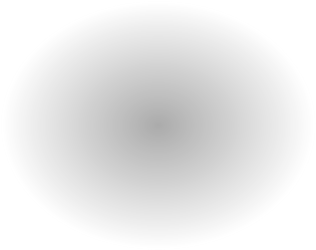
s **Blood transfusions**

**To put blood in your veins.**

s **Surgery** s **Medicines**

**End of life care – if you might die soon your medical decision maker can:**

* + **call in a spiritual leader**



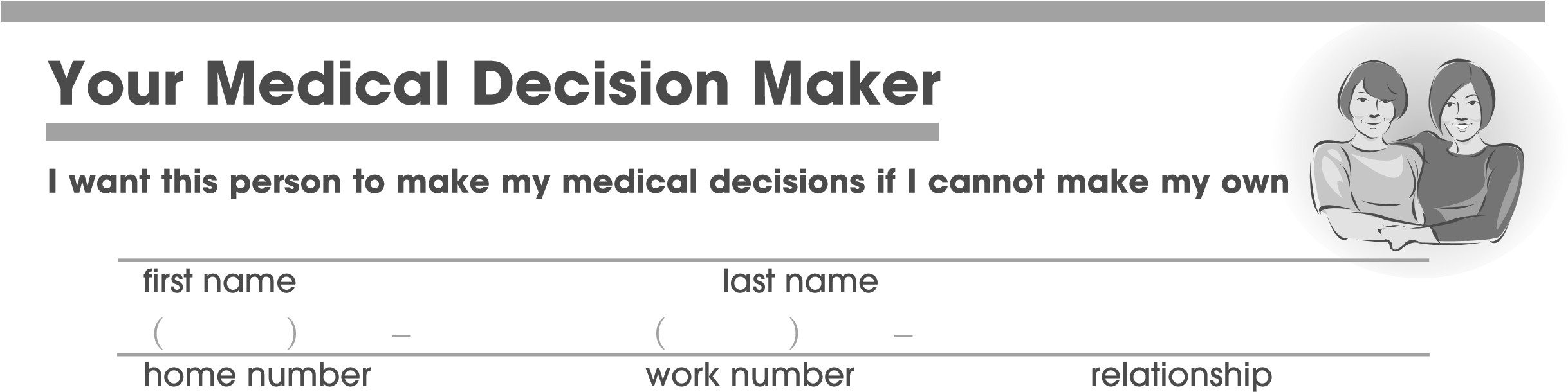
* + **decide if you die at home or in the hospital**
  + **decide where you should be buried**

**Show your medical decision maker this form.**

**Tell your decision maker what kind of medical care you want.**

**4**

**Part 1: Choose your medical decision maker Pennsylvania Advance Health Care Directive**



**street address city state zip code**

**If the first person cannot do it, then I want this person to make my medical decisions.** Also, if the first person is a spouse and you divorce, the doctors will turn to this person.

**first name last name**

( ) – ( ) –

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **home number** |  |  | **work number** |  | **relationship** |
| **street address** |  |  | **city** |  | **state zip code** |

**Put an X next to the sentence you agree with.**

* **My medical decision maker can make decisions for me right after I sign this form.**
* **My medical decision maker will make decisions for me only after I cannot make my own decisions.**

**How do you want your medical decision maker to follow your healthcare wishes? Put an X next to the one sentence you most agree with.**

* **Total Flexibility: It is OK for my decision maker to change any of my medical decisions if my doctors think it is best for me at that time.**
* **Some Flexibility: It is OK for my decision maker to change some of my decisions if the doctors think it is best. But, these are some wishes I never want changed:**
* **No flexibility: I want my decision maker to follow my medical wishes exactly, no matter what. It is not OK to change my decisions, even if the doctors recommend it.**

**To make your own health care choices go to Part 2 on the next page.**

**If you are done, you must sign this form on page 9.**

**Pennsylvania Advance Health Care Directive**

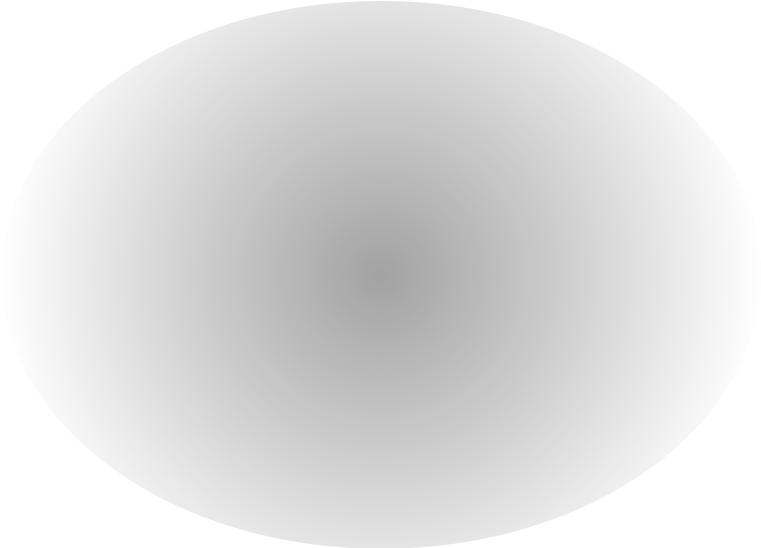
**Part 2 Make your own health care choices**

**Write down your choices so those who care for you will not have to guess.**

**Think about what makes your life worth living.**

**Put an X next to all the sentences you most agree with.**

**My life is only worth living if I can:**



m **talk to family or friends** m **wake up from a coma**

m **feed, bathe, or take care of myself** m **be free from pain** m **live without being hooked up to machines** m **My life is always worth living no matter how sick I am** m **I am not sure**

**If I am dying, it is important for me to be:**

* **at home** o**in the hospital** o**I am not sure**

**Is religion or spirituality important to you?**

* **no** o**yes If you have one, what is your religion?**

**What should your doctors know about your religious or spiritual beliefs?**

**If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.**

**YOUR NAME:**

**6**

**Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.**

**Please read this whole page before you make your choice.**

**Put an X next to the one choice you most agree with.**

**If I am so sick that I may die soon:**

* **Try all life support treatments that my doctors think might help.** **If the treatments do not work and there is little hope of getting better, I want to stay on life support machines even if I am suffering.**
* **Try all life support treatments that my doctors think 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. If I am suffering, I want to stop.**



* **I do not want life support treatments, and I want to focus on being comfortable. I prefer to have a natural death.**
* **I want my medical decision maker to decide for me.**
* **I am not sure.**

**\*If you are pregnant and become unable to make decisions: Pennsylvania law may require your doctor to give you life support treatments even if you have an advance directive.**

**If you want to write down medical wishes that are not on this form, go to page 9.**

**YOUR NAME:**

**Your doctors may ask about organ donation and autopsy after you die. Please tell us your wishes.**

**Put an X next to the one choice you most agree with. Donating (giving) your organs can help save lives.**

* **I want to donate my organs. Which organs do you want to donate?**



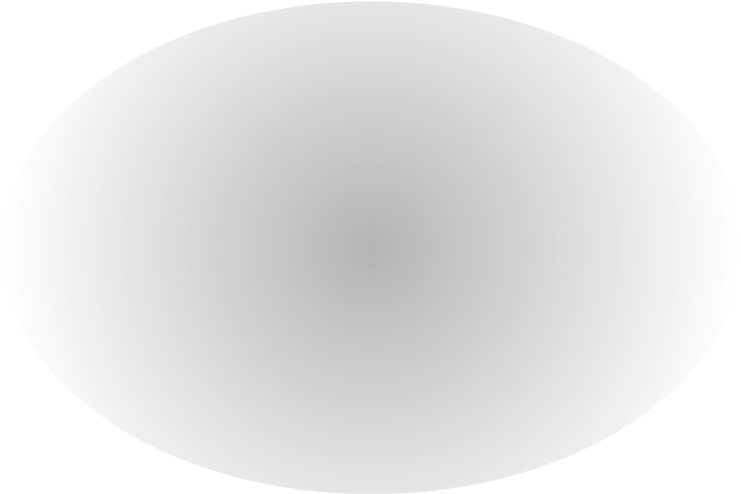
m**any organ**

## monly\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* **I do not want to donate my organs.** o**I want my decision maker to decide.**  o**I am not sure.**

**An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.**

* **I want an autopsy.** o**I do not want an autopsy.**
* **I**  **only want an autopsy if there are questions about my death.** o**I want my decision maker to decide.** o**I am not sure.**



**What should your doctors know about how you want your body to be treated after you die? Do you have funeral or burial wishes?**

**8**

**YOUR NAME:**

**What other wishes are important to you?**

**Part 3**

**Sign the form**

**Before this form can be used, you must:**

s

**sign this form if you are at least 18 years of age**

s

**have two witnesses sign the form**

**Sign your name and write the date.**

/ /

**sign your name date**

**print your first name print your last name**

**address city state zip code**

**Pennsylvania Advance Health Care Directive**

**Your witnesses must:**

**B efore this form can be used you must have**

**2**

**witnesses sign the form**

**Part 3**

**Witnesses**

s **be over 18 years of age** s **know you** s **see you sign this form Your witnesses cannot:**



s **be your medical decision maker** s **be your health care provider** s **work for your health care provider** s **work at the place that you live Also, one witness cannot:**

s **be related to you in any way** s **benefit financially (get any money or property) after you die**

**Witnesses need to sign their names**

**on the next page.**

**10**

**Have your witnesses sign their names and write the date**

**By signing, I promise that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ signed this form while I watched.**

**(name)**

**He/she was thinking clearly and was not forced to sign it. I also promise that:**

s **I know this person and he/she could prove who he/she was.**

s **I am 18 years or older** s **I am not his/her medical decision maker** s **I am not his/her health care provider** s **I do not work for his/her health care provider** s **I do not work where he/she lives One witness must also promise that:**

s ) AM NOT RELATED TO HIMHER BY BLOODMARRIAGEOR ADOPTION

|  |  |
| --- | --- |
| **Part 3: Sign the form** | **Pennsylvania Advance Health Care Directive** |

### s ) WILL NOT BENEFIT FINANCIALLY GET ANY MONEY OR PROPERTY AFTER HESHE DIES

**Witness #1**

## / /

|  |  |  |
| --- | --- | --- |
| **sign your name** | **date** |  |
| **print your first name** | **print your last name** |  |
| **address** | **city state** | **zip code** |
| **Witness #2** | **/ /** |  |
| **sign your name** | **date** |  |

**print your first name print your last name**

**address city state zip code**

**You are now done with this form.**

**Share this form with your family, friends, and medical providers.**

|  |  |
| --- | --- |
| **Part 3: Sign the form** | **Pennsylvania Advance Health Care Directive** |

**Talk with them about your medical wishes**



This advance directive is in compliance with the Pennsylvania Probate Code 20 PA. C.S.A. §§ 5421-5431. **12 © 2015 Rebecca Sudore, MD**

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