Advance Directive

MY NAME ..... DATE OF BIRTH ..... DATE SIGNED.....

ADDRESS .....

CITY.. STATE ..... ZIP.....

PHONE ..... EMAIL.....

PART 1: MY HEALTH CARE AGENT

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

   * *Normally these statements are separate choices, but it is conceivable that they could be concurrent.*

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.)

   Address: _____
   Relationship (optional): _____
   Tel. (daytime): _____ (evening): _____
   cellphone: _____ email: _____

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): _____ (evening): _____
   cellphone: _____ 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): _____ (evening): _____
   cellphone: _____ email: _____

4. _____ I want to appoint two or more people to be co-agents and have listed them on page two of this Part.

Appointment of "co-agents"

You can appoint co-agents — people you ask to make decisions for you, acting together, based upon a discussion of your circumstance and agreement on a course of action or treatment. Sometimes co-agents have difficulty making decisions together. Before completing this part, be sure this is the best choice for you and your co-agents.

Not all of the people you ask to be co-agents may be readily available to speak for you or to make decisions that have to be made immediately, particularly in an emergency. For this reason, it is a good idea to give additional directions about how decisions can be made by your co-agents.

5. Co-agents I appoint are:

Name: _____ Relationship (optional): _____
Address: _____
Phone (specify work, home or cell): _____

Name: _____ Relationship (optional): _____
Address: _____
Phone (specify work, home or cell): _____

Name: _____ Relationship (optional): _____
Address: _____
Phone (specify work, home or cell): _____

(repeat below for additional co-agents)

6. I prefer that decisions made by the co-agents named above be made in the following way (you may choose one or prioritize 1,2,3):

_____ by agreement of all co-agents
_____ by a majority of those present, or
_____ by the first person available, if it is an emergency.

7. Other Instructions for co-agents (optional):

_____
_____
_____
_____
_____
_____

NAME _____ DOB _____ DATE _____

PART 2: OTHERS WHO ARE OR MAY BECOME INVOLVED IN MY CARE

1. My Doctor or other Health care Clinician:

   Name: _____ Address: _____

   Phone: _____ _____

   (or)

   Name: _____ Address: _____

   Phone: _____ _____

2. Other people whom my agent ***may*** be consulted about medical decisions on my behalf:

   _____

   _____

   Those who should ***not*** be consulted by my agent include:

   _____

   _____

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

   _____

   _____

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.

   Name: _____ Address: _____

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: _____ Address: _____

   Phone: _____ _____

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

   Alternate preferred guardians: _____

   Persons I would not want to be my guardian: _____

   _____

Name _____ DOB _____ Date _____

Part 3: Statement of Values and Goals

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

…. And general advice about how to approach medical choices depending upon your current or future state of health or the chances of success of various treatments.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name _____ DOB _____ Date _____

Part 4: End-of-Life Treatment Wishes

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

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) _____

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.

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

NAME _____ DOB _____ DATE _____

PART 5: OTHER TREATMENT WISHES

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 treatments 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
   _____ any other treatment to extend my life
   _____ Other: _____

4. _____ If the likely **costs, 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

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

   Hospital/Facility: _____ Tel: _____
   Address.: _____ _____

   Hospital/Facility: _____ Tel: _____
   Address.: _____ _____

   Reason for preference: _____

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

   Hospital/Facility: _____ Reason: _____

   Hospital/Facility: _____ Reason: _____

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

   _____

   Avoid use of the following medications or treatments: (List medications/treatments)

   _____ Reason:_____

   _____ Reason:_____

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.

9. **Mental Health Treatment**

   A. **Emergency Involuntary Treatment.** If it is determined that an emergency involuntary treatment must be provided for me, I prefer these interventions in the following order: (List by number as many as you choose. For example, 1 = first choice; 2 = second choice, etc. You may also note the type of medication and maximum dosage.)

   _____ Medication in pill form

   _____ Liquid medication

   _____ Medication by injection

   _____ Physical restraints

   _____ Seclusion

   _____ Seclusion and physical restraints combined

   _____ Other: _____

   Reason for preferences above (optional): _____

   B. **Electro-convulsive Therapy (ECT) or "Electro-Shock Treatment"**: If my doctor thinks that I should receive ECT and I am not legally capable of consenting to or refusing ECT, my preference is indicated below:

   _____ I **do NOT** consent to the administration of any form of ECT.

   _____ I **consent** / **do not consent** *(circle one)* to unilateral ECT

   _____ I **consent** / **do not consent** *(circle one)* to bifrontal ECT

   _____ I **consent** / **do not consent** *(circle one)* to bilateral ECT

   _____ I **consent** (or authorize my agent to consent) to ECT as follows:

   ____ I agree to the number of treatments the attending Psychiatrist considers appropriate.

   ____ I agree to the number of treatments Dr. _____considers appropriate.

   ____ I agree to the number of treatments my agent considers appropriate.

   ____ I agree to no more than the following number of treatments_____.

   Other instructions regarding the administration of ECT:

   _____

   _____ I acknowledge that I and my agent have been apprised of and will follow the uniform informed consent procedures and the use of standard forms to indicate consent to ECT per 18 V.S.A 7408.

NAME _____ DOB _____ DATE _____

PART 6: WAIVER OF RIGHT TO REQUEST OR OBJECT TO FUTURE TREATMENT

I hereby give my agent _____ the authority to consent to or refuse the following treatment(s) over my objection if I am determined by two clinicians to lack capacity to make healthcare decisions at the time such treatment is considered:

1. **I *do* want** the following treatment to be provided, even over my objection, at the time the treatment is offered: _____

   I do *not* want the following treatment, even over my request for that treatment, at the time the treatment is offered: _____

2. I give permission for my agent to agree to have me admitted to a designated hospital or treatment facility even over my objection.

   _____ Yes _____ No

3. I give my agent permission to agree that my release from a voluntary admission for mental health treatment may be delayed even over my objection for up to four days so that a decision can be made regarding whether I meet criteria to be involuntarily committed.

   _____ Yes _____ No

4. I hereby affirm that I am knowingly and voluntarily waiving the right to refuse or request specified treatment at a time of incapacity, and that I understand that my doctor and one other clinician will determine whether or not I have capacity to make health care decisions at that time. I know that I can revoke this part of my Advance Directive only when I have the capacity to do so, as determined by my doctor and at least one other clinician.

   Signed: _____ , Principal Date: _____

(Continued next page)

Acknowledgements

Acknowledgement by Agent — I hereby accept the responsibility of consenting to or refusing the treatments specified above, even if to do so would be against the principal's expressed wishes at the time treatment is considered.

Signed: *(Agent)*_____ and *(Alternate)*_____

Print names: _____ _____

Phone: _____ _____

Date: _____ _____

Acknowledgement of principal's clinician — I affirm that the principal appears to understand the benefits, risks, and alternatives to the health care specified above that is being consented to or refused by the principal.

Signed: _____ Title: _____

Facility: _____ Date: _____

Please print name: _____

Acknowledgement by persons who explain Part 6 — I, as the designated person to explain Part 6, affirm that I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in Vermont, or a probate court designee and that I have:

- Explained the nature and effect of this Waiver of the Right to Request or Object to Treatment to the principal, and
- The principal appears both to understand the nature and effect of this provision and to be free from duress or undue influence.
- If the principal is in a hospital at the time of signing, that I am not affiliated with that hospital, and
- I am not related to the principal, a reciprocal beneficiary, or the principal's clergy or a person who has exhibited special care and concern for the principal.

Signed: _____

Position: _____ Date: _____

Name _____ DOB _____ Date _____

Part 7: 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.)*

_____ I wish to donate the following organs and tissues:

____ any needed organs or tissues
____ major organs (heart, lungs, kidneys, etc.)
____ tissues such as skin and bones
____ eye tissue such as corneas
____ I wish my agent to make any decisions for anatomical gifts (or)
____ I wish the following person(s) to make any decisions:

_____

_____

_____ 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.)

_____ I do not wish to be an organ donor.

NAME _____ DOB _____ DATE _____

PART 8: MY WISHES FOR DISPOSITION OF MY BODY AFTER MY DEATH

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

   _____ 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)*:

   _____ 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:

   Name: _____

   Address: _____

   Telephone: _____

   Cellphone: _____ Email: _____

   (or)

   _____ I want my family to decide.

3. If an **autopsy** is suggested following my death:

   _____ 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:

   Name: _____

   Address: _____

   Telephone: _____

Name _____ DOB _____ Date _____

Part 9: Signed Declaration of Wishes

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.

Signed: _____ Date: _____

(Optional) I affirm that I have given or will give copies of my Advance Directive to my Agent(s) and Alternate Agent(s) and that they have agreed to serve in that role if called upon to do so.

Signed: _____ Date: _____

(Optional) I affirm that I have given or will give a copy of my Advance Directive to my Doctor or Clinician.

Signed: _____ Date: _____

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 this Advance Directive if the principal is a current patient or resident in a *hospital, or other health care facility.*

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 court 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.

Name: _____ Title/position: _____

Address: _____

Tel.: _____ Date: _____

Important!

Please list below the people and locations that will have a copy of this document:

_____**Vermont Advance Directive Registry** (anticipated available by mid- 2007)

____ **Health care agent(s)**

____ **Alternate health care agent**

_____ **Family members:** (List by name all who have copies)

Name _____

Address _____

Name _____

Address _____

Name _____

Address _____

Name _____

Address _____

Name _____

Address _____

_____ MD (Name)_____Address_____

_____ Hospital (s) (Names)_____

_____ Other individuals or locations:

_____

_____

_____

_____

_____

_____