TERMINAL CARE DOCUMENT
(LIVING WILL)
VERMONT STANDARD FORM

(Please print clearly, except where signature is required)

To my family, my physician, my lawyer, my clergyman. To any medical facility in whose care I happen to be. To any individual who may become responsible for my health, welfare or affairs.

Death is as much a reality as birth, growth, maturity and old age — it is the one certainty of life. If the time comes when I, ... of .... , can no longer take part in decisions for my future, let this statement stand as an expression of my wishes, while I am still of sound mind.

If the situation should arise in which I am in a terminal state and there is no reasonable expectation of my recovery, I direct that I be allowed to die a natural death and that my life not be prolonged by extraordinary measures. I do, however, ask that medication be mercifully administered to me to alleviate suffering even though this may shorten my remaining life.

Other directions:

....

....

....

....

....

This statement is made after careful consideration and is in accordance with my strong convictions and beliefs. I want the wishes and directions here expressed carried out to the extent permitted by law. Insofar as they are not legally enforceable, I hope that those to whom this Will is addressed will regard themselves as morally bound by these provisions.

Date: .... , 20..........................

Signature: .... *Date of Birth:* ....

Address: ....

WITNESSING PROCEDURES

This document will not be valid unless it is signed in the presence of *two (2) or more qualified witnesses* who must both be present when you sign or acknowledge your signature. *The following persons may not act as witnesses:*

- your attending physician or the person acting under the direction or control of the attending physician;
- your spouse;
- your lawful heirs or beneficiaries named in your will or a deed;
- creditors or persons who have a claim against you.

Witness: .... *Address:* ....

Witness: .... *Address:* ....

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

DISCLOSURE STATEMENT

THIS IS AN IMPORTANT DOCUMENT.
BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you when you are no longer capable of making them yourself. "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition. Your agent, therefore, can have the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment.

You may describe in this document any treatment you do not desire or treatment you want to be sure you receive. Your agent's authority will begin when your doctor certifies that you lack the capacity to make health care decisions. You may attach additional pages if you need more space to complete your statement.

Your agent will be obligated to follow your instructions when making decisions on your behalf. *Unless you state otherwise*, your agent will have the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care providers before you sign it to make sure that you understand the nature and range of decisions which may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is a legal matter in this document that you do not understand, you may want to ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust and must be at least 18 years old. If you wish to appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home or residential care home other than a relative), that person will have to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want him or her to be your health care agent. *You should discuss this document with your agent and give him or her the original signed copy.* You should indicate on the document itself the people and institutions who will have photocopies of the original. Your agent will not be liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing him or her or your health care provider orally or in writing.

This document may not be changed or modified once you have signed it. If you want to make changes in the document, you must make an entirely new one.

You may wish to appoint an alternate agent in the event that your agent is unwilling, unable or ineligible to act as your agent. Any alternate agent you select will have the same authority as the agent to make health care decisions for you.

WITNESSING PROCEDURES

This power of attorney will not be valid unless it is signed in the presence of *two (2) or more qualified witnesses* who must both be present when you sign or acknowledge your signature. *The following persons may not act as witnesses:*

- the person you have designated as your agent or alternate agent;
- your health or residential care provider or any of his/her employees;
- your spouse;
- your lawful heirs or beneficiaries named in your will or a deed;
- creditors or persons who have a claim against you.

WORKSHEET 1 – VALUES QUESTIONNAIRE

The following questions can help you think about your values as they relate to medical care decisions. You may use the questions to discuss your views with your health care agent and others, or you may write answers to the questions as a help to your agent and health care team. (If you fill out this worksheet and want it to be part of your DPA/HC, sign it in the presence of witnesses and attach it to your DPA/HC form.)

1. What do you value most about your life? (For example: living a long life, living an active life, enjoying the company of family and friends, etc.) ....

....

2. How do you feel about death and dying? (Do you fear death and dying? Have you experienced the loss of a loved one? Did that person's illness or medical treatment influence your thinking about death and dying?) ....

....

....

3. Do you believe life should always be preserved as long as possible? ....

....

4. If not, what kinds of mental or physical conditions would make you think that life-prolonging treatment should no longer be used? Being:

- unaware of my life and surroundings;
- unable to appreciate and continue the important relationships in my life;
- unable to think well enough to make every-day decisions;
- in severe pain or discomfort;
- other (describe): ....

....

5. Could you imagine reasons for temporarily accepting medical treatment for the conditions you have described? What might they be? ....

....

6. How much pain and risk would you be willing to accept if your chances of recovery from an illness or injury were good (50-50 or better)? ....

....

7. What if your chances of recovery were poor (less than one in 10)? ....

....

8. Would your approach to accepting or rejecting care depend on how old you were at the time of treatment? Why? ..

....

....

9. Do you hold any religious or moral views about medicine or particular medical treatments? What are they? ....

....

....

10. Should financial considerations influence decisions about your medical care? Explain. ....

....

....

11. What other beliefs or values do you hold that should be considered by those making medical care decisions for you if you become unable to speak for yourself? ....

....

....

12. Most people have heard of difficult end-of-life situations involving family members or neighbors or people in the news. Have you had any reactions to these situations? If so, describe: ....

....

....

Date: .... *Signature:* .... *Date of birth:* ....

Address: ....

Witness: .... *Witness:* ....

WORKSHEET 2 – MEDICAL SITUATIONS & THEIR TREATMENT

This worksheet presents possible treatment plans for a variety of common medical situations. You may use these examples to discuss your views with your health care agent and others, or you may write down your choices as a help to your agent and health care team. (If you fill out this worksheet and want it to be part of your DPA/HC, sign it in the presence of witnesses and and attach it to your DPA/HC form.)

Possible Treatment Plans:

A. I would want all possible efforts to preserve life as long as possible.

B. I would want comfort care only, and would not want medical treatment, including tube-feeding, to prolong my life.

C. I would want comfort care and tube-feeding, but would not want other types of medical treatment to prolong my life.

D. My agent should consider the possible benefits and burdens of disease-fighting treatment, and consent only to treatment that he or she believes is in my best interests, as we have discussed them. My agent may refuse any active treatment or may consent to a trial of treatment and then stop treatment if it is not beneficial.

E. Treatment plan D, as described above, except that I would always want tube-feeding.

Possible Medical Situations:

1. Suppose you have a fatal ("terminal") condition. You are unconscious and death is expected soon, with or without treatment. What treatment plan would you want? (Select from above, or write your own.) ....

....

....

2. Suppose you are permanently unconscious from an accident or severe illness. There is no reasonable hope of recovering awareness, but life support could keep your body alive for years. (This is called "persistent vegetative state" or "permanent coma.") What treatment plan would you want? (Select from above, or write your own.) ....

....

....

3. Suppose you are in a state of very advanced loss of mental capability, due perhaps to stroke or Alzheimer's disease. You cannot recognize or communicate with those close to you, and can do almost nothing for yourself. You could survive in this state for some time with medical treatment. What treatment plan would you want? (Select from above, or write your own.) ....

....

....

4. Suppose you are in a state of permanent but not total confusion, perhaps from stroke or Alzheimer's disease. You are legally "incompetent" and cannot recognize people and interact with them in a meaningful way, but you are up and around and people are taking care of you. You are not in distress and seem to be able to experience some satisfactions in daily life, such as in eating or hearing music. Then you get an illness that might be fatal. What treatment plan would you want? (Select from above, or write your own.) ....

....

5. Suppose you are frail, chronically ill and uncomfortable, with a limited range of activities available to you. Then you become unconscious, at least temporarily, due to an acute illness. The illness is likely to be fatal unless vigorously treated in a hospital, but even intensive care offers only a small chance of recovery to your former condition. It's much more likely that you will end up worse off than before, or will die in spite of all heroic measures. What treatment plan would you want? (Select from above, or write your own.) ....

....

6. Suppose you unexpectedly suffer a serious injury or illness. You have less than a 5 percent chance of good recovery and, if you survive, will have serious brain damage. What treatment plan would you want? (Select from above, or write your own.)

....

....

7. Use this space to describe any other medical situations you'd like to address: ....

....

....

....

Date: .... *Signature:* .... *Date of birth:* ....

Address: ....

Witness: .... *Witness:* ....

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
VERMONT STANDARD FORM

(Please print clearly, except where signature is required)

I, ... of...,
hereby appoint .... of...
as my *agent* to make any and all health care decisions for me, *except to the extent I state otherwise* in this document. This durable power of attorney for health care shall take effect in the event I become unable to make my own health care decisions. Should the person I have appointed be unable, unwilling or unavailable to act as my health care agent, I hereby appoint .... of.. as my *alternate agent.*

(A) STATEMENT OF DESIRES, SPECIAL PROVISIONS AND LIMITATIONS REGARDING HEALTH CARE DECISIONS. Here you may include any specific desires or limitations you feel are appropriate, such as when or what life-sustaining measures should be started or withheld; directions whether or not to use artificial nutrition and hydration; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason. (If you want to include instructions about life-sustaining treatment, read Part B before filling out this section.)

....
....
....
....

(attached additional worksheets or pages as necessary)

(B) THE SUBJECT OF LIFE-SUSTAINING TREATMENT IS OF PARTICULAR IMPORTANCE. For your convenience in dealing with this subject, some general statements concerning life-sustaining treatment are set forth below. IF YOU AGREE WITH ONE OF THE STATEMENTS, YOU MAY COPY IT IN THE SPACE PROVIDED ABOVE.

1. If I suffer a condition from which there is no reasonable prospect of regaining my ability to think and act for myself, I want only care directed to my comfort and dignity, and authorize my agent to decline all treatment (including artificial nutrition and hydration) the primary purpose of which is to prolong my life.
2. If I suffer a condition from which there is no reasonable prospect of regaining the ability to think and act for myself, I want care directed to my comfort and dignity and also want artificial nutrition and hydration if needed, but authorize my agent to decline all other treatment the primary purpose of which is to prolong my life.
3. I want my life sustained by any reasonable medical measures, regardless of my condition.

I hereby acknowledge that I have been provided with a *disclosure statement* (see other side) explaining the effect of this document. I have read, or had read to me, and understand the information contained in the disclosure statement. The original of this document will be held by my *agent,* and photocopies of the original will be given to my *alternate agent* and the following:

....
....
....

In witness whereof, I have hereunto signed my name this date of ...., 20 ....

Signature: .... *Date of Birth:* ....

Address: ....

I declare that the principal appears to be of sound mind and free from duress at the time the durable power of attorney for health care is signed and that the principal has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

Witness: .... *Address:* ....

Witness: .... *Address:* ....

The following is required *only* if this document is being signed while the principal is in or being admitted to a hospital, nursing home or residential care home.

Statement of ombudsman, hospital representative, recognized member of the Vermont clergy, Vermont-licensed attorney or other person designated by the county Probate Court: I declare that I have personally explained the nature and effect of this durable power of attorney to the principal and that the principal understands the same.

Date: ....

Name: .... *Address:* ....

This pull-out section includes:

- **Durable Power of Attorney for Health Care Form and Disclosure Statement**
- **Terminal Care Document**
- **Worksheet 1 – Values Questionnaire**
- **Worksheet 2 – Medical Situations and Their Treatment**

Checklist for the Durable Power of Attorney

These steps may be helpful to you as a reminder of things that might be good to check on as you plan and fill out the document:

- ❑ I have talked with my agent and alternate agent, if any, about this document before appointing them and they understand my wishes.
- ❑ I have included my agent(s) addresses and phone numbers on the document or on an attachment which will be included with all copies.
- ❑ I have listed the people to whom I have given or plan to give copies.
- ❑ I have an extra copy for myself. (If either I or my agent makes additional copies for others to have, we will communicate this to each other when these copies are made and distributed.)
- ❑ My family and friends have been included in this process to the extent that I wish them to be involved or informed of my wishes.
- ❑ I have talked this over with my primary care physician and s/he understands my wishes.
- ❑ I understand that I should review this document every few years to make sure it still accurately expresses my wishes.