ADVANCE DIRECTIVE FOR HEALTH CARE

Your Name: _____ **Date of Birth:** _____

Address: _____

YOUR HEALTH CARE AGENT

Your health care agent can make health care decisions for you when you can not make decisions for yourself. You should pick someone that you trust. Talk to them about your wishes. Tell them that you are making them your agent in this advance directive.

I want this person to be my healthcare agent.

Name: _____

Address: _____

Phone Home: _____ Work Phone: _____

Cell Phone: _____ Email: _____

I want this person to be my alternate agent if the first person cannot do it.

Name: _____

Address: _____

Phone Home: _____ Work Phone: _____

Cell Phone: _____ Email: _____

I want my advance directive to start:

- ☐ When I cannot make my own decisions
- ☐ Now
- ☐ When this happens: _____

YOUR TREATMENT WISHES

You can write down what kind of medical treatment you want or do not want in this section. These are your choices. Talk to your doctor if you have questions.

My wishes for end of life care (initial your choices):

_____ I want **all** possible medical treatment to sustain life.

_____ I **do not** want the following medical treatment (check your choices):

- ☐ breathing machine
- ☐ feeding tube
- ☐ food by IV
- ☐ fluid by IV
- ☐ other treatments _____

_____ I **do not** want any medical treatment to extend my life.

_____ I want care that preserves my dignity and provides comfort and relief from pain and other symptoms that bother me. I want pain medication even if it might make me die sooner.

Other Wishes:

_____

_____

_____

I plan to give a copy of my advance directive to:

- ☐ My agent. They have agreed to be my agent: **Yes** ☐ / **No** ☐.
- ☐ My doctor
- ☐ The online registry
- ☐ Other: _____

SIGNATURE AND WITNESSES

You must sign this before two adult witnesses. Your agent, spouse, partner, brother, sister, parent, child, grandchild, or reciprocal beneficiary cannot be a witness.

You must sign and date the Advance Directive.

These are my wishes regarding my medical care. I am signing this advance directive of my own free will.

Sign your name here _____ Date _____

Your witnesses must sign and date the Advance Directive.

I affirm that the Principal appeared to understand the nature of this advance directive and to be free from duress or undue influence at the time this was signed.

First Witness Signature _____ Date _____

Print name _____

Address (Town, State) _____

Second Witness Signature _____ Date _____

Print name _____

Address (Town, State) _____

Patients and residents of hospitals, nursing homes, or residential care homes must have this section signed.

I explained the nature and effect of this advance directive to the Principal.

Ombudsman/Clergy/Attorney/Court Designee/Hospital Rep _____ Date _____