Vermont Advance Directive for Health Care

Prepared by the Vermont Ethics Network • Registry Compatible

Explanation and Instructions

- You have the right to give instructions about what types of health care you want or do not want.
- You also have the right to name someone else to make health care decisions for you when you are unable to make them yourself. You may also have that person's authority begin immediately or upon any chosen circumstances.
- You may do either of these by telling your family or your doctor, but it is generally better for you and your family if you write down your wishes in an Advance Directive.
- You may use this form in its entirety or you may use any part of it. For example, if you simply want to choose an agent in ***Part One***, you may do so and go directly to ***Part Five*** to sign this in the presence of appropriate witnesses.
- You are also free to use a different form as long as it is properly signed and witnessed.

Part One of this form lets you name a person as your ***"agent"*** to make health care decisions for you if you become unable or unwilling to make your own decisions. You may also name co-agents or alternate agents. You should choose as your agent (and alternates) people you trust, who are going to be comfortable making what might be hard decisions on your behalf. They should know you and be guided by your values in making choices for you.

You should notify your agents that you have named them, and they need to agree to act as your agent if asked to do so. Your agent does not have authority to make decisions for you until the time you specify or when you are unable to make your own decisions.

Part Two of this form lets you state ***Treatment Wishes.*** Choices are provided for you to express your wishes about having, not having, or stopping treatment necessary to keep you alive under certain circumstances. Space is also provided for you to write out any additional or specific wishes based on your values, health condition, or beliefs.

Part Three of this form lets you express your wishes about ***organ and tissue donation.***

Part Four is for you to express your wishes about ***funeral arrangements*** *or other provisions for your remains after you die.*

Part Five of this form is for ***signatures***. You must sign and date the form in the presence of two adult witnesses. The following persons may ***not*** be witnesses: your agent(s), your spouse or partner, reciprocal beneficiary, siblings, parents, children, or grandchildren.

You should give ***copies*** of the completed form to your agent(s), your physician, your family, and to any health care facility at which you are likely to receive care or treatment. You may also send your Advance Directive to the **Vermont Advance Directive Registry** at the address at the end of this form where your copy locations are listed. This will allow any hospital or other provider to have quick access to your AD document should the need arise.

You have the right to revoke or suspend all or part of this Advance Directive for health care or replace this form at any time. If you do revoke it, all old copies should be destroyed.

You may wish to read the booklet *Taking Steps* to help you think about and discuss different choices and situations with your agent or loved ones.

Advance Directive

PRINT NAME ..... DATE OF BIRTH (DOB) ..... DATE .....

ADDRESS .....

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

Part One: Appointment of My Health Care Agent

I appoint .....

ADDRESS .....

TEL. (DAY) ..... (EVENING) .....

CELLPHONE ..... EMAIL .....

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 document.** *If you appoint co-agents, list above or on a separate sheet of paper.*

If this health care agent is unavailable, unwilling, or unable to do this for me,

I appoint ..... to be my **alternate agent**.

ADDRESS: .....

TEL. (DAY) ..... (EVENING) .....

CELLPHONE ..... EMAIL .....

Use additional sheets to appoint more than one agent or alternates.

Others who can be consulted about medical decisions on my behalf include:

.....

.....

Those who should *not* be consulted include:

.....

.....

Your agents should have been notified that you appointed them. They should understand your wishes and agree to make health care decisions for you when you are no longer able to, or wish to, make those decisions for yourself. It is also advisable that you discuss this document with your doctor.

(Optional) Use the space below to identify your doctor or health care provider.

PRIMARY CARE PHYSICIAN OR CLINICIAN .....

ADDRESS ..... TELEPHONE .....

OTHER HEALTH CARE PROFESSIONAL .....

ADDRESS ..... TELEPHONE .....

Print Name _____ DOB _____ Date _____

Part Two: Treatment Wishes

Please express your preferences that follow by initialing or checking the statements. ***You may initial more than one choice.*** *Draw a line through any statement you do not agree with. If you do nothing, your agent or others such as family members and doctors treating you will assume you want them to decide for you.* ***If you do not state a preference for withholding or withdrawing artificial food and hydration (tube feeding), your agent may not have authority to withhold or withdraw it, without a court order, if you are being treated in a New York or New Hampshire hospital.***

_____ **A. My choice is to limit treatment**.
(Initial or check those statements below that you agree with.)

____ **1.** I do not want to be kept alive if I am so sick that I will die within a relatively short time (I cannot get better and have only weeks, days, or hours left to live).

____ **2.** I do not want to be kept alive if I become unconscious or unaware of my surroundings and most doctors agree that I will never regain consciousness.

____ **3.** I do not want to be kept alive if I become unable to think or act for myself (and won't get better).

____ **4.** I do not want to be kept alive if the likely risks and burdens of treatment would outweigh the expected benefits. *(Specify what is most important for you.)*

_____ **5.** If it is possible that I might recover with treatment and **more time is needed** to determine if I can get better or not, I wish my medical team to start the necessary treatments to keep me alive. If, over time, these treatments do not improve my chances of living or my physical condition, I wish to have life-sustaining treatment stopped.

_____ **6.** If I am also unable to swallow enough food and water to stay alive, I **do** want food and water to be given to me by vein or by feeding tube. (or)

_____ **7.** If I am also unable to swallow enough food and water to stay alive, I **do not** want food and water to be given to me by vein or feeding tube; however, I will accept medication for pain and agitation via an IV line.

_____ **8.** Other specific instructions are as follows (continue on next page if needed):

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.....

_____ **B. My choice is to sustain life.** I want to be kept alive as long as possible through any means possible regardless of my condition or awareness.

Print Name _____ DOB _____ Date _____

Other specific instructions continued from the previous page

Specific Care Wishes Near the End of My Life

_____ If it becomes clear to my doctor, my agent, and those caring for me that I am dying, I want palliative care for my pain, worries, nausea, and other conditions that bother me. I want sufficient **pain medication** even though it may have the unintended effect of hastening my death.

_____ I want **hospice care** when I am dying, if possible and appropriate.

_____ I prefer to **die at home**, if this is possible.

Spiritual and Other Care Concerns

I am of the _____ faith. Below is the contact information (if known).

Church, synagogue, or worship center:

ADDRESS

LEADER TEL.

Other people to notify if I have a life-threatening illness:

The following items or music or readings would be a comfort to me:

Print Name _____ DOB _____ Date _____

Part Three: Instructions about Organ and Tissue Donation

I wish to make known my decisions regarding organ and tissue donation and whole body donation so that my instructions will be followed after my death.

I **consent to donate** the following organs and tissues:

____ any needed organs (such as heart, lung, kidney, liver)

____ any needed tissue (such as cornea, bone, and skin)

I do **not** wish to donate the following organs and tissues:

.....

.....

____ I wish to make **no decision** about organ and tissue donation at this time.

____ My health care agent in Part One of this Advance Directive shall be entitled to make decisions about organ and tissue donation. (or)

____ I appoint the following person, or persons, to make decisions regarding an anatomical gift at the time of my death.

NAME .....

ADDRESS .....

PHONE ..... CELLPHONE .....

EMAIL .....

SIGNED ..... *DATE* .....

____ I do **not** wish to be an organ and tissue donor.

____ I desire to donate my body to research or an educational program *(Note: you will have to make your own arrangements <u>in advance</u> through a medical school or other program.)*

____ If an **autopsy** is suggested for any reason, I give my permission to have it done.

Print Name _____ DOB _____ Date _____

Part Four: My Wishes for Disposition of My Remains Following My Death

I. The person I want to serve as my agent for disposition of my body:

a. _____ 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.

b. _____ Regardless of my appointment of a health care agent in Part One, I appoint the following person to decide about and arrange for the disposition of my body after my death:

NAME ..... EMAIL .....

ADDRESS .....

TEL. ..... CELLPHONE .....

(or)

c. _____ I want my family to decide.

II. My preference 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 state where the burial plot is located and whether it has been prepurchased):*

.....

.....

.....

_____ I want to be cremated and have my ashes buried or distributed as follows:

.....

.....

.....

_____ I want to have arrangements made at the direction of my agent or family.

III. I have a pre-need contract for funeral arrangements with the following funeral service:

NAME .....

ADDRESS .....

TEL. .....

Print Name _____ DOB _____ Date _____

Part Five: Signed Declaration of Wishes

This document reflects my desires regarding my future health care, organ and tissue donation, and disposition of my body after death. I am signing this Advance Directive of my own free will.

SIGNED ..... **DATE** .....

The witnesses below affirm that the signer of this document appeared to understand the nature of the document he or she signed and that he or she appeared to be free from duress or undue influence at the time the document was signed. *The following people may **not** sign as witnesses: your agent(s), spouse, reciprocal beneficiary, parents, siblings, children, or grandchildren.*

(Please sign and print)

FIRST WITNESS .....

ADDRESS .....

SECOND WITNESS .....

ADDRESS .....

*If the person signing this document is a current patient or resident in a hospital, nursing home or residential care home, an **additional person** (designated hospital explainer, long-term care ombudsman, member of the clergy, Vermont attorney, or person designated by the probate court) needs to confirm below that he or she has explained the nature and effect of the Advance Directive and the patient or resident signing it appears to understand this.*

NAME ..... TITLE/POSITION .....

ADDRESS ..... DATE .....

Print Name _____ DOB _____ Date _____

Who Has a Copy of My Advance Directive

Please check below the people and locations that will have copies of this document.

_____ Health care agent _____ Alternate health care agent

_____ Hospital (name, city, state) .....

.....

_____ MD (name and address) .....

_____ Family members (list by name and relationship) .....

.....

.....

.....

_____ Vermont Advance Directive Registry **(c/o USLWR, P.O. Box 2789, Westfield, NJ 07091-2789)**

Please send a copy of your form along with a transmittal cover sheet that may be obtained from your local hospital or the Vermont Ethics Network. Be sure to use enough postage.

_____ Others who have copies include: .....

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Explanation & Instructions

Advance Directive Forms