

Advance Directive for Health Care

*respecting
your
right to:*

Choose Your Healthcare Agent

Choose the Authority Given to Your Healthcare Agent

Choose Your Preferences Related to Treatment & Care

Printed Name

Birthdate

Explanation and Directions for this Advance Directive:

- This is an important legal document that allows you to define your preferences as it relates to your future healthcare.
- This is a way to communicate these preferences to those who care about you (friends, family and others) and for your healthcare providers (like your doctor).
- This document activates only when you are unable to or choose not to make healthcare decisions for yourself.
- **PART ONE** is your choice for a healthcare agent and alternates. This is the person(s) you choose to make healthcare decisions on your behalf.
- **PART TWO** is your choices for treatment preferences including your choices in requesting or refusing medical treatment.
- **PART THREE** is the signatures needed to make this document legal. You may fill out either Part One, Part Two, or both, but IF you have filled out ANY section of this form then Part Three MUST be filled in to make it legal.
- This document does NOT give permission for:
 - 1) your healthcare agent to make business or financial decisions on your behalf
 - 2) your healthcare agent to make behavioral health treatment, sterilization, treatment or involuntary hospitalization for mental or emotional illness, or addictive disease decisions on your behalf

What do you do with an old advance directive (GA Advance Directive, Living Will, etc.)?

- Destroy any paper copies.
- Direct another person to destroy it in your presence.
- Revoke it by signing a written & dated statement or by stating that it is revoked in the presence of a witness.

How often should you consider making changes to your advance directive?

You will want to review and update your advance directive when one of the following occurs:

- Decade – at the start of a new decade of your life
- Death – if a loved one or your healthcare agent dies
- Divorce – if you marry someone other than your healthcare agent or if you divorce your healthcare agent, then this ADHC is automatically revoked
- Diagnosis – if you are diagnosed with a serious illness
- Decline – if your health gets worse, especially if you are no longer able to live on your own

Steps to take after completing this Advance Directive:

1. Talk to the person(s) you named as your healthcare agent(s) about your goals and preferences for future medical care. Ensure they feel they can serve in this important role.
2. Give your healthcare agent a copy of your completed advance directive.
3. Talk to your family & close friends. Ensure they know who your agent(s) is and what your preferences are.
4. Give a copy to your doctor AND your healthcare facility so they are aware of your preferences.
5. Keep a copy where it can easily be found.
6. If you are going to the hospital or a nursing home, take a copy of this document with you and ask that it be placed in your medical record.

Need help completing this document?

Contact a Respecting Choices advance care planning facilitator at nghs.com/respecting-choices to schedule an appointment.

PART ONE: My choice for healthcare agent

(Part 1 will be effective even if Part 2 is not completed)

Who should you choose as your healthcare agent?

- Someone who knows you well and cares about you
- Someone you trust to make difficult decisions
- Someone who will respect your goals and values
- Someone who will be a good advocate for you
- Someone 18 years or older

Who must not be your healthcare agent?

- Your healthcare provider if they are directly involved in your care
- Someone less than 18 years old

If I can no longer make my own healthcare decisions (or I choose not to), this advance directive names the person I authorize to make these choices on my behalf; even if I do not fill out my treatment preferences in the next part. This person will be my healthcare agent.

The person I choose as my healthcare agent:

Name _____ Relationship _____

Telephone(Cell) _____ (Work) _____ (Home) _____

Address _____

Email Address(optional) _____

If my healthcare agent cannot be contacted within a reasonable time period or for any reason is unable or unwilling to act as my healthcare agent, then I select the following back up healthcare agents to be contacted in order of choice.

Second choice:

Name _____ Relationship _____

Telephone(Cell) _____ (Work) _____ (Home) _____

Address _____

Email Address(optional) _____

Third choice:

Name _____ Relationship _____

Telephone(Cell) _____ (Work) _____ (Home) _____

Address _____

Email Address(optional) _____

By checking this box, I'm indicating that I do not have a healthcare agent. Instead, please allow my selections on Part Two to guide my healthcare decisions.

PART ONE: My choice for healthcare agent (Continued)

(Part 1 will be effective even if Part 2 is not completed)

Authority given to my healthcare agent:

I understand that I have chosen a healthcare agent to make decisions for me related to my health care. They will have the same authority to make any healthcare decision that I could make. A court can take the powers of my healthcare agent if it finds they are not acting properly. **Initial beside each statement that you authorize for my healthcare agent.**

1. ____ Take my instructions and what he or she knows of my preferences and values to act in my best interest.
2. ____ Make the decision to request, take away or not give any type of healthcare.
3. ____ Authorize or refuse any medication or procedure to help with pain.
4. ____ Consent to admit me to an assisted living facility, hospital, hospice or nursing home. My healthcare agent can hire (or fire if needed) any kind of healthcare worker I may need to help me or take care of me.
5. ____ Contract for any healthcare facility or service for me, which will not make my healthcare agent liable to pay for these services.
6. ____ Review and release my medical records as needed for my medical care.
7. ____ Accompany me in any ambulance if a passenger is permitted. Visit me in any healthcare facility if visitation is permitted.
8. ____ Apply for Medicare, Medicaid or other programs or insurance benefits for me.
9. ____ Decide on organ and body donation for medical purposes after my death according to my preferences and values.
10. ____ Request or decline an autopsy after my death according to my preferences and values, unless required by law.
11. ____ Determine disposition of my body for use in a medical study program after my death according to my preferences and values.
12. ____ In case of pregnancy, I understand that under Georgia law, my treatment preferences will not be in effect if I am pregnant and the fetus is viable. By initialing this statement, I want my treatment preferences to be carried out if the fetus is not viable.
13. ____ Listed below are any changes, additions or limitations on my healthcare agent's powers:

— End Part One —

PART TWO: My choice for treatment preferences

(Part 2 will be effective even if Part 1 is not completed.)

This is your opportunity to make your preferences clear. Your healthcare agent(s) and your doctors will refer to this section as they care for you. If you did not name a healthcare agent(s) or if your healthcare agent(s) cannot be reached, you can direct your care with the choices you indicate below. You should talk with your healthcare agent(s) about the kind of care you want, even if you do not make selections in this section.

With any choice below, I understand I will be kept clean and comfortable and continue to receive pain and comfort medicines. If I am able to swallow safely, I may receive food and fluids by mouth. **Initial each statement you choose as your preference.**

Treatments that may prolong life if I am in this situation:

1. If I have a **terminal illness** (incurable or irreversible condition) and the doctors believe I will die within a short period of time, this is my choice:

a) _____ **I want to extend my life for as long as possible** using all treatments that the doctors believe are reasonable. Some examples are a machine that breathes for me (respirator/ventilator), feeding tubes, blood products, antibiotics, or fluids given to me through an IV, treatments for chronic medical conditions or other medications.

OR

b) _____ **I want to allow my natural death** to occur by refusing or stopping all treatments except:

i) _____ If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.

ii) _____ If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.

iii) _____ If I need assistance to breathe, I want to have a ventilator/respirator used.

2. If I have **permanent and severe brain damage** in which I will NOT recover the ability to know who I am, who my family and friends are, or where I am, this is my choice:

a) _____ **I want to extend my life for as long as possible** using all treatments that the doctors believe are reasonable. Some examples are a machine that breathes for me (respirator/ventilator), feeding tubes, blood products, antibiotics, or fluids given to me through an IV, treatments for chronic medical conditions or other medications.

OR

b) _____ **I want to allow my natural death** to occur by refusing or stopping all treatments except

i) _____ If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.

ii) _____ If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.

iii) _____ If I need assistance to breathe, I want to have a ventilator/respirator used.

3. Cardiopulmonary resuscitation (CPR)*

Based on my current health, this is my choice about CPR if my heart stops (*Initial one*):

_____ **I want CPR**

_____ **I want CPR attempted UNLESS my doctor determines:**

- I have a medical condition with no reasonable chance of survival with CPR, OR
- CPR would harm me more than help me.

_____ **I do not want CPR. Let me die a natural death.**

*If you do not want emergency personnel to give you CPR, you will need to talk to your doctor about completing the Georgia Physician Orders for Life Sustaining Treatment (POLST).

PART TWO: My choice for treatment preferences (Continued)
(Part 2 will be effective even if Part 1 is not completed.)

My choice for preferences related to comfort measures:

(Initial each statement you would like your family to provide.)

- I would like referral options related to Palliative Care & Hospice.
- I would like enough medicine to keep me free from pain-even if I will be more drowsy or sleepy.
- I would like massages.
- I would like warm blankets.
- I would like grooming such as the personal care of nails, hair, and teeth as long as they don't appear to cause me pain.
- I would like music played. My favorite songs/artists/genres are: _____

- I would like to be read to. My favorite books/magazines/authors are: _____

- I would like visits from a spiritual caregiver: My spiritual caregiver's name and contact information (if applicable) _____

- Other choices I would like as comfort measures: _____

My choice for preferences related to my death:

- Organ donation (Initial one):
 - I do not wish to donate any part of my body.
 - I wish to donate any parts of my body that may help others.
 - I wish to donate certain organs & tissues: _____
- After my death, I would like my body to be (circle one): buried or cremated
- My funeral home preference is _____
- I would like my remains placed in the following location _____
- Memorial Service (Initial one):
 - Yes, please include the following music, songs, readings and requests: _____

 - No

— End Part Two —

PART THREE: Making this Advance Directive for Health Care Legal

You will sign and date (or acknowledge signing and dating) this form in the presence of two witnesses. Both witnesses must be emotionally and mentally capable and at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form. A witness:

- Cannot be a person who was selected to be your healthcare agent or back-up healthcare agent(s)
- Cannot be a person who will gain financially from your death
- Cannot be a person who is directly involved in your healthcare

Only one of the witnesses may be an employee, agent or medical staff member of the hospital, skilled nursing facility, hospice or other healthcare facility in which you are receiving healthcare (but again, this person cannot be directly involved in your healthcare).

By signing this form all previous advance directives for healthcare, durable power of attorney for healthcare, healthcare proxy or living will are canceled.

My signature and date

This form revokes any advance directive for healthcare, durable power of attorney for healthcare, healthcare proxy, or living will that I have completed before this date.

I am emotionally and mentally capable of making this advance directive and I understand its purpose and effect. I agree with everything written in this document and have completed this document of my free will.

Signature _____ Date _____

My witnesses

I know this to be the person identified in this document.
This person signed this form in my presence or acknowledged signing this form to me. I believe this person to be emotionally and mentally capable of making this advance directive. I am at least 18 years old and I signed this form willingly and voluntarily.

Witness Number One:

Signature _____ Date _____

Printed Name of Witness _____

Address _____

Witness Number Two:

Signature _____ Date _____

Printed Name of Witness _____

Address _____

*This form does NOT need to be notarized.