

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 choices 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 your healthcare agent to:**
 - 1) **make business or financial decisions on your behalf**
 - 2) **make behavioral health treatment, sterilization, treatment or involuntary hospitalization for mental or emotional illness, or addictive disease decisions on your behalf**

Steps to take after completing this Advance Directive:

- Talk to the person(s) you named as your healthcare agent and alternates about your goals and preferences for future medical care. Be sure he/she feels he/she can serve in this important role.
- Talk to your family and close friends. Be sure they know who your agent and alternates are and what your preferences are.
- Give your healthcare agent a copy of your completed advance directive. Make copies and give to your doctor and healthcare facility
- Keep a copy where it can easily be found.
- 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.

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 and 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?

It is good to review and update your advance directive when one of the following occurs:

- Decade – at the start of a new decade of your life (i.e., every 10 years)
- Death – if your healthcare agent dies and you need to name a new agent or if your choices have changed after the death of a loved one
- Divorce – if you marry someone other than your healthcare agent or if you divorce your healthcare agent, then this document is automatically revoked
- Diagnosis – if you are diagnosed with a serious illness
- Decline – if your health gets worse over time, especially if you are no longer able to live on your own

Need help completing this document?

Contact a Respecting Choices advance care planning facilitator at nghs.com/respecting-choices to ask a question or 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 will respect your goals and values
- Someone you trust to make decisions in difficult circumstances
- Someone who will be a good advocate for you and follow your decisions, even if he/she may not agree with them
- Someone 18 years or older

Who must NOT be your healthcare agent?

- Your healthcare provider if he/she is directly involved in your care
- Someone younger 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 on page 4)

PART ONE: My choice for healthcare agent (Continued from page 3)

(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. He/she will have the same authority to make any healthcare decision that I could make, including:

- Take my instructions and what he or she knows of my preferences and values to act in my best interest.
- Authorize, request, refuse, withdraw, and/or withhold any and all types of medication, treatment, procedures or healthcare.
- Consent, negotiate and/or contract for any healthcare facility or service for me, such as assisted living, skilled nursing facility, hospital or hospice or nursing home. These actions will not make my healthcare agent liable to pay for these services.
- Admit or discharge me from any healthcare facility.
- Sign and/or deliver any documents or contracts needed for my health care.
- Review and release my medical records as needed for my medical care.
- Accompany me in any ambulance if a passenger is permitted. Visit me in any healthcare facility if visitation is permitted.

Note: Under Georgia law, a court can take away the powers of your healthcare agent if it finds he/she is not acting in accordance with your preferences. Your healthcare agent DOES NOT have the power to make decisions regarding behavioral health treatment, sterilization, treatment or involuntary hospitalization for mental or emotional illness, or addictive disease.

Authority given to my healthcare agent after death:

I understand all of the following authorities are also given to my healthcare agent.

Only initial those you DO NOT want your healthcare agent to have.

Autopsy – My healthcare agent WILL have the power to authorize (give permission) for an autopsy unless initialed below to limit his/her authority (power).

_____ (Initial) I do NOT give the authority to my healthcare agent to authorize an autopsy
(unless required by law).

Organ Donation and/or Body Donation – My healthcare agent WILL have the power to donate my body for use in a medical study and/or donate any of my organs unless initialed below to limit his/her authority.

_____ (Initial) I do NOT give authority to my healthcare agent to donate my body for use in a medical study.

_____ (Initial) I do NOT give authority to my healthcare agent to donate any of my organs.

Final Disposition of Body – My healthcare agent WILL have the power to authorize the final disposition of my body including funeral arrangements and burial or cremation unless I have initialed below to limit his/her authority.

_____ (Initial) I do NOT give authority to my healthcare agent to make decisions about the final disposition
of my body.

I want the following person to make decisions about the final disposition of my body:

Name _____

Address _____

Phone _____

Initial your preference for the final disposition of your body:

_____ (Initial) I want to be buried.

_____ (Initial) I want to be cremated.

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. If you chose a healthcare agent in Part One, then he/she will have the authority to make all healthcare decisions for you regarding matters in Part Two. Your healthcare agent or alternates and your doctors will refer to this section as a guide as they care for you. If you did NOT name a healthcare agent or alternates or if your he/she cannot be reached, you can direct your care with the choices you indicate below.

Part Two will only be activated if you are unable to communicate. Your condition of permanent unconsciousness or terminal illness will be documented in writing after personal examination by your attending physician and a second physician.

WITH ANY CHOICE BELOW, I understand I will be kept clean and comfortable and continue to receive pain and comfort medicines.

Initial each statement you choose as your treatment preferences that may prolong life if you are in this situation:

1. If I have a **terminal illness** (an 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, medications, and/or fluids given to me through an IV or treatments for chronic medical conditions.
 - or
 - b) ☐ **I want to allow my natural death** to occur by refusing or stopping all treatments except any I choose below (i, ii, iii):
 - 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.

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2. If I have a **state of permanent unconsciousness** (an incurable or irreversible condition) in which the doctors believe I am not expected to recover the ability to know who I am, who my friends and family 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, medications, and/or fluids given to me through an IV or treatments for chronic medical conditions.
 - or
 - b) ☐ **I want to allow my natural death** to occur by refusing or stopping all treatments except any I choose below (i, ii, iii):
 - 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.

PART TWO: My choice for treatment preferences (Continued from page 5)

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

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).*

4. _____ **In case of pregnancy**, I understand that under Georgia law, my treatment preferences will not be in effect if the fetus is viable. By initialing this statement, I want my treatment preferences in Part Two to be carried out if the fetus is not viable.

My choice for preferences related to comfort measures:

(Check the following comfort measures you would like your family to provide.)

_____ 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) _____

_____ 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.

_____ Other choices I would like as comfort measures (such as warm blankets, massages, etc.): _____

My choice for preferences after my death:

My choices for autopsy, organ donation, and/or disposition of body by burial or cremation are listed in Part One: Authority of My Healthcare Agent. Below are my preferences after death that I would like my loved ones to know.

- My funeral home preference is _____

- I would like my remains placed in the following location _____

- Memorial Service (check one):

_____ Yes

_____ No

- Please include the following music, songs, readings and requests: _____

PART THREE: Making this Advance Directive for Health Care Legal

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).

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. This form does not revoke an advance directive for behavioral health treatment.

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

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.