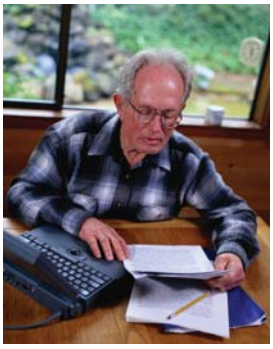

Sample Combined Advance Healthcare Directive

This sample advance directive is provided for information and illustration. Advance directive forms vary from state to state, so be sure to check with your health care provider and choose a form approved for use in the state where you live. State-specific advance directive forms are available online at www.caringinfo.org.

Before you sign

Read this form carefully. Choose which sections you wish to include, and fill in the blanks. If you want to add specific instructions in your own words, you may do so. If you need more space, attach extra sheets and sign or initial at the bottom of each sheet.

After you sign

Have two witnesses sign, also. Witness requirements vary, so check to make sure your witnesses are right under the law in your state. If you are appointing a health care representative, sit down with him/her and talk about your wishes and goals for your care. Give copies to: (1) your health care representative, if you are appointing one; (2) your doctor and other health care providers, such as your hospital, home health care agency, or nursing facility; (3) close family members or friends. When you give them a copy of your advance directive, take some time to explain what it says and what your wishes are.

Words You Need to Know

An **Advance Directive** is an instruction (usually in writing) that says how you want future health care decisions made for you if you can't make them yourself.

Artificial Nutrition and Hydration is when food and water are given to a person through a tube or needle because the person is no longer able to swallow.

Autopsy is an examination done on a body to find out the cause of death.

Comfort Care is care that helps to keep a person comfortable and control pain.

CPR (Cardiopulmonary Resuscitation) is emergency treatment that tries to restart a person's breathing or heartbeat after they have stopped. CPR can include pushing on the chest, putting a tube down the throat, and other emergency steps.

Health Care Appointment is an advance directive in which you appoint someone to make medical decisions for you if the time ever comes when you can't make them yourself. It is also called a "Health Care Proxy" or a "Durable Power of Attorney for Healthcare."

Life-Sustaining Treatment is any medical treatment that is used to keep a person from dying. A breathing machine, CPR, and artificial nutrition and hydration are examples of life-sustaining treatments.

Health Care Directive is an advance directive in which you say what forms of medical treatment you do or do not want if you become terminally ill or are in a persistent vegetative state.

Organ and Tissue Donation is when a person permits his/her organs (such as eyes or kidneys) and other parts of the body (such as skin) to be removed after death to be transplanted to another person or used for education or research.

Persistent Vegetative State is when a person is unconscious with no hope of regaining consciousness even with medical treatment. The body may move and eyes may be open, but as far as anyone can tell, the person can't think or respond.

Being **Terminally Ill** means having an injury or illness that has no cure and from which doctors expect the person to die, even with medical treatment.

Combined Advance Directive of:

Name _____ Date _____

I. Health Care Appointment

I hereby appoint the following person as my health care representative. I intend for my representative to have the power to act for me in making health care decisions on my behalf if, in the opinion of my primary physician, I am incapacitated and unable to make such decisions for myself.

Name of person I appoint: _____

Address: _____

Home/Work Phone: _____

If the person I have just named is unable or unwilling to act as my representative, I appoint as alternate:

Name of alternate: _____

Address: _____

Home/Work Phone: _____

Special instructions or wishes concerning my future care: _____

_____

_____

_____

_____

_____

II. Health Care Directive

These are my wishes if I become terminally ill or am in a persistent vegetative state and cannot make decisions about my care:

I ❑ do or ❑ do not want *life-sustaining treatments* (including CPR) started or continue.

Other wishes:_____

_____

_____

I ❑ do ❑ do not want **artificial nutrition and hydration** started or continued if it would be the main treatment keeping me alive.

Other wishes:_____

_____

_____

Unless you specify otherwise, an advance directive will not limit or prevent comfort care as directed by your doctor.

III. Organ Donation

I ❑ do ❑ do not want to be an organ or tissue donor.

❑ I want to donate all my organs and tissues

❑ I only want to donate the following organs and tissues.

Other wishes:_____

_____

_____

IV. Autopsy

❑ I do not want an autopsy, if one is not legally required.

❑ I agree to an autopsy if my doctor recommends it.

Other wishes:_____

_____

_____

V. Guardianship

If it becomes necessary for a court to appoint a guardian for me, I nominate my health

care representative acting under this document to be the guardian of my person, to serve without bond or security.

VIII. Signatures

You and two witnesses must sign this document. If you are physically unable to sign your name, you may direct another person (but not one of your witnesses) to sign for you.

A. Your Signature

By my signature below I show that I understand the purpose and effect of this document and that I am signing it as an expression of my own wishes concerning my future care.

Signature: _____ Date: _____

Address _____

_____

B. Your Witnesses' Signatures

- I hereby declare and affirm as true:
- I personally know the person who has signed above, or his/her identity has been clearly established;
- This person signed this document in my presence;
- This person appears to me to be of sound mind and not under any form of duress, fraud, or undue influence;
- I am qualified to be a witness;
- I am not: ✔ someone this person has appointed as health care representative or alternate; ✔ a relative of this person; ✔ someone who will inherit from or who has a claim against this person; ✔ this person's doctor or other care provider or an employee thereof; ✔ paying for this person's care.

[Note: Witness requirements vary from state to state. For example, if you are receiving care in a nursing facility, California and some other states require that one witness be an ombudsman or other type of patient advocate. Be sure to check on witness requirements in your state.]

Witness #1

Signature: _____ Date: _____

Address _____

Witness #2

Signature: _____ Date: _____

Address _____