ADVANCE DIRECTIVE

Your Durable Power of Attorney for Health Care, Living Will and Other Wishes

INSTRUCTIONS AND DEFINITIONS

Introduction

This form is a combined ***Durable Power of Attorney for Health Care*** and ***Living Will*** for use in the District of Columbia, Maryland and Virginia. Any hospital, health care provider or other licensed health care facility will recognize and accept this form as your statement of your wishes for care, when you are not able to speak for yourself.

With this form, you can:

- Appoint someone to make medical decisions for you if you in the future are unable to make those decisions for yourself
- Indicate what medical treatment you do or do not want if in the future you are unable to make your wishes known.

As you complete this form, talk it through with your family, your physician, those you trust, your pastor or other spiritual leader. The experience of creating advance directives is both personal and emotional. It is easier to think this through before health problems arise.

Directions

1. Read each section carefully.
2. Talk to the person you name in the durable power of attorney for healthcare to make sure that s/he understands your wishes, and is willing to take the responsibility.
3. Place the initials of your name in the blank before those choices you want to make.
4. Fill in only those choices that you want under Parts 1, 2 and 3. Your advance directive should be valid for whatever parts you fill in, as long as it is properly signed.
5. Add any special instructions in the blank spaces provided. You can write additional comments on a separate sheet of paper, but should indicate on the form that there are additional pages to your advance directive.
6. Sign the form and have it witnessed. No lawyer is needed and the form does not require notarization.
7. Give your doctor, nurse, the person you appoint to make your medical decisions for you, your family, and anyone else who might be involved in your care, a copy of your advance directive and discuss it with them. Bring a copy with you each time you are admitted to any hospital.
8. Understand that you may change or cancel this document at any time.

PROVIDENCE HOSPITAL

The Mission of Providence

Rooted in the loving ministry of Jesus as healer, we serve all persons with joy, care, and respect, giving special attention to persons who are poor and vulnerable. Our Catholic health ministry improves the health of individuals and of our community with compassion and justice.

Words You Need to Know

Advance Directive: A written document that tells what a person wants or does not want if he/she in the future cannot make his/her wishes known about medical treatment.

Artificial Nutrition and Hydration: When food and water a fed to a person through a tube.

Autopsy: An examination done on a dead body to find the cause of death.

Comfort Care: Care that helps to keep a person comfortable but does not make him/her better. Bathing, turning, keeping a person's lips moist are types of comfort care.

CPR (Cardiopulmonary Resuscitation): Treatment to try and restart a person's breathing or heartbeat. CPR may be done by pushing on the chest, by putting a tube down the throat, and/or by other treatment.

Durable Power of Attorney for Health Care: An advance directive that appoints someone to make medical decisions for a person if in the future he/she cannot make his/her own medical decisions.

End-Stage Condition: Any chronic, irreversible condition caused by injury or illness that has caused serious, permanent damage to the body. A person in an end-stage condition requires others to provide most of his/her care.

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

Living Will: An advance directive that tells what medical treatment a person does or does not want if he/she is not able to make his/her wishes known.

Organ and Tissue Donation: 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 for use by another person or to be used for experimental purposes.

Persistent Vegetative State: 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 cannot think or respond.

Terminal Condition: An on-going condition caused by injury or illness that has no cure and from which doctors expect the person to die, even with medical treatment. Life-sustaining treatments will not improve the person's condition and only prolong a person's dying.

ADVANCE DIRECTIVE

District of Columbia, Maryland and Virginia

My Durable Power of Attorney for Health Care, Living Will and Other Wishes

I, _____ write this document as my directive regarding medical care.
(Please print your name clearly)

Part 1 MY DURABLE POWER OF ATTORNEY FOR HEALTH CARE

As long as I can make my wishes known, my doctors will talk to me and I will make my own health care decisions. If I am unable to speak for myself, I authorize…

Please initial each box below as to your wishes	Your Directives	Contact Information	
Initial here if this applies	I appoint this person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself.	Person's Name	
		Home Phone	
		Work Phone	
		Address	
Initial here if this applies	If the person above cannot or will not make decisions for me, I appoint this person.	Person's Name	
		Home Phone	
		Work Phone	
		Address	
Initial here if this applies	I have not appointed anyone to make health care decisions for me in this or any other document. I understand that if I do not appoint a Durable Power of Attorney for Health Care, someone may be designated to make my health care decisions by law or by a court.	This space intentionally left blank.	

I want the person I have appointed on the previous page, my doctors, my family and others to be guided by the decisions I have made below.

Part 2 MY LIVING WILL

These are my wishes for my future medical care if there ever comes a time when I cannot make these decisions for myself.

A. In general, these are the goals I have for my care if I am ever seriously ill or have a serious injury (state in your own words what you believe is most important to you):

Please put the initials of your name next to important values for you if you are ever seriously ill or have a serious injury:

Initial each box below if this is what you want	The values that should drive your care
Initial here if this applies	Medicines needed to keep me pain-free
Initial here if this applies	Ability to recognize my family and friends
Initial here if this applies	Other values:

B. These are my wishes if I have a <u>terminal condition:</u>

Initial each box below if this is what you want	My choices on life sustaining treatments if I have a <u>terminal condition:</u>
Initial here if this applies	I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.
Initial here if this applies	I want life-sustaining treatments (including CPR) started on a temporary basis; if I do not show signs of recovery, then I want them stopped.
Initial here if this applies	I want life-sustaining treatments continued that my doctors think are best for me.
Initial here if this applies	Other wishes:

Initial each box below if this is what you want	My choices on artificial nutrition and hydration if I have a terminal condition:
Initial here if this applies	I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.
Initial here if this applies	I want artificial nutrition and hydration, even if it is the main treatment keeping me alive.
Initial here if this applies	Other wishes:

C. These are my wishes if I am ever in a persistent vegetative state:

Initial each box below if this is what you want	My choices for life-sustaining treatments if I am ever in a persistent vegetative state:
Initial here if this applies	I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.
Initial here if this applies	I want life-sustaining treatments (including CPR) started on a temporary basis; if I do not show signs of recovery, then I want them stopped.
Initial here if this applies	I want life-sustaining treatments continued that my doctors think are best for me.
Initial here if this applies	Other wishes:

Initial each box below if this is what you want	My choices for artificial nutrition and hydration if I am ever in a persistent vegetative state:
Initial here if this applies	I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.
Initial here if this applies	I want artificial nutrition and hydration, even if it is the main treatment keeping me alive.
Initial here if this applies	Other wishes:

D. These are my wishes if I ever have an End-Stage Condition (including Alzheimer's or other dementia):

Initial each box below if this is what you want	My choices for life-sustaining treatments if I ever have an End-Stage Condition (including Alzheimer's or other dementia):
Initial here if this applies	I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.
Initial here if this applies	I want life-sustaining treatments (including CPR) started on a temporary basis; if I do not show signs of recovery, then I want them stopped.
Initial here if this applies	I want life-sustaining treatments continued that my doctors think are best for me.
Initial here if this applies	Other wishes:

Initial each box below if this is what you want	My choices for artificial nutrition and hydration if I ever have an End-Stage Condition (including Alzheimer's or other dementia):
Initial here if this applies	I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.
Initial here if this applies	I want artificial nutrition and hydration, even if it is the main treatment keeping me alive.
Initial here if this applies	Other wishes:

E. Other Directions

You have the right to be involved in all decisions about your medical care, even those not dealing with terminal conditions, persistent vegetative state or end-stage conditions. If you have wishes not covered in other parts of this document, please indicate them here:	

Part 3 OTHER WISHES

A. Organ Donation

Initial each box below if this is what you want	My choice for any organ or tissue donation are:
Initial here if this applies	I do not wish to donate any of my organs or tissues.
Initial here if this applies	I want to donate all of my organs and tissues.
Initial here if this applies	I only want to donate these organs and/or tissues
Initial here if this applies	Other wishes regarding organ or tissue donation:

B. Autopsy

Initial each box below if this is what you want	My choice regarding an autopsy:
Initial here if this applies	I do not want an autopsy.
Initial here if this applies	I agree to an autopsy if my doctors wish it.
Initial here if this applies	Other wishes regarding autopsy:

Part 4 SIGNATURES

You and two witnesses must sign this document in order for it to be legal. The witnesses may not be the person named under the first section, durable power of attorney for health care decisions. The witness may not be involved in your care in any way.

A. Your Signature

By my signature below, I show that I understand the purpose and the effect of this document.

Signature _____ Date _____

Address _____

B. Your Witnesses' Signatures

I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence, and that he/she appears not to be acting under pressure, duress, fraud or undue influence. I am not related to the person making this advance directive by blood marriage or adoption, nor, to the best of my knowledge, am I named in his/her will. I am not the person appointed in this advance directive. I am not a health care provider or an employee of a health care provider who is now, or has been in the past, responsible for the care of the person making this advance directive.

Witness #1

Signature _____ Date _____

Address _____

Witness #2

Signature _____ Date _____

Address _____