Sample Advance Directive Form

This form is a combined durable power of attorney for health care and a living will (in some jurisdictions). With this form, you can name someone to make medical decisions for you if in the future you're unable to make those decisions yourself. You can also say what medical treatments you want and what medical treatments you don't want if in the future you're unable to make your wishes known.

Instructions

Read each section carefully. Before you fill out the form talk to the person you want to name, to make sure that he/she understands your wishes and is willing to take the responsibility. Write your initials in the blank spaces before the choices you want to make. Write your initials only beside the choices you want under Parts 1, 2 and 3 of this form. Your advance directive should be valid for whatever part(s) you fill in, as long as it is properly signed.

Add any special instructions in the blank spaces provided. You can write additional comments on a separate sheet of paper, but you should write on this form that there are additional pages to your advance directive. Sign the form and have it witnessed. Give copies to your doctor, your nurse, the person you name to make your medical decisions for you, people in your family and anyone else who might be involved in your care. Discuss your advance directive with them.

Understand that you may change or cancel this document at any time.

Definitions to Know

Advance directive—A written document (form) that tells what a person wants or doesn't want if he/she in the future can't make his/her wishes known about medical treatment.

Artificial nutrition and hydration—When food and water are 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 doesn't make him/her get well. Bathing, turning and keeping a person's lips moist are types of comfort care.

CPR (cardiopulmonary resuscitation)—Treatment to try to restart a person's breathing or heartbeat. CPR may be done by pushing on the chest, by putting a tube down the throat or by other treatment.

Durable power of attorney for health care—An advance directive that names someone to make medical decisions for a person if in the future he/she can't make his/her own medical decisions.

Life-sustaining treatment—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.

Living will—An advance directive that tells what medical treatment a person does or doesn't 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 the eyes or kidneys) and other parts of the body (such as the 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 the eyes may be open, but as far as anyone can tell, the person can't think or respond.

Terminal condition—An ongoing 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 only prolong the dying process if the person is suffering from a terminal condition.

Complete this portion of advance directive form

I, _____, write this document as a directive regarding my medical care.

In the following sections, put the initials of your name in the blank spaces by the choices you want.

PART 1. My Durable Power of Attorney for Health Care

_____ **I appoint this person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself. I want the person I have appointed, my doctors, my family and others to be guided by the decisions I have made in the parts of the form that follow.**

Name: _____

Home telephone: _____ Work telephone: _____

Address: _____

_____

If the person above cannot or will not make decisions for me, I appoint this person:

Name: _____

Home telephone: _____ Work telephone: _____

Address: _____

_____

_____ I have not appointed anyone to make health care decisions for me in this or any other document.

PART 2. My Living Will

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

A. These are my wishes if I have a terminal condition.

Life-sustaining treatments

_____ I do not want life-sustaining treatment (including CPR) started. If life-sustaining treatments are started, I want them stopped.

_____ I want the life-sustaining treatments that my doctors think are best for me.

_____ Other wishes _____

Artificial nutrition and hydration

_____ I do not want artificial nutrition and hydration started if they would be the main treatments keeping me alive. If artificial nutrition and hydration are started, I want them stopped.

_____ I want artificial nutrition and hydration even if they are the main treatments keeping me alive.

_____ Other wishes _____

Comfort care

_____ I want to be kept as comfortable and free of pain as possible, even if such care prolongs my dying or shortens my life.

_____ Other wishes _____

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

Life-sustaining treatments

_____ I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.

_____ I want the life-sustaining treatments that my doctors think are best for me.

_____ Other wishes _____

Artificial nutrition and hydration

_____ I do not want artificial nutrition and hydration started if they would be the main treatments keeping me alive. If artificial nutrition and hydration are started, I want them stopped.

_____ I want artificial nutrition and hydration even if they are the main treatments keeping me alive.

_____ Other wishes _____

Comfort care

_____ I want to be kept as comfortable and free of pain as possible, even if such care prolongs my dying or shortens my life.

_____ Other wishes _____

C. Other directions

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

_____

_____

_____

_____

_____

_____

_____

_____

_____

PART 3. Other Wishes

A. Organ donation

_____ I do not wish to donate any of my organs or tissues.

_____ I want to donate all of my organs and tissues.

_____ I only want to donate these organs and tissues: _____

_____ Other wishes _____

B. Autopsy

_____ I do not want an autopsy.

_____ I agree to an autopsy if my doctors wish it.

_____ Other wishes _____

C. Other statements about your medical care

If you wish to say more about any of the choices you have made or if you have any other statements to make about your medical care, you may do so on a separate piece of paper. If you do so, put here the number of pages you are adding: _____

PART 4. Signatures

You and two witnesses must sign this document before it will be legal.

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 _____

Adapted with permission from the District of Columbia Hospital Association, 1250 Eye, N.W., Suite 700, Washington, DC 20005; telephone: 202-682-1581; fax: 202-371-8151.