Completing The Advance Directive For Health Care

This advance directive has two parts. Part A designates the appointment of a health care agent. A health care agent is a person you appoint to make health care decisions for you when you can no longer do so. **Part B** states your particular health care instructions. These instructions will be used by your health care providers and your health care agent to make decisions about your care if you cannot do it yourself.

- You may appoint a health care agent by filling out **Part A**; or
- You may state your health care instructions by filling out **Part B**; or
- You may do both by filling out both **Part A and Part B**.

PART A

1. In this section you name your health care agent. You may also name an alternate health care agent. This is optional, but strongly recommended, in case your primary agent is unavailable when a decision must be made. If you do not wish to appoint a health care agent, cross through this section.

2. This section describes the authority you give to your health care agent. Cross through any sections you do not want to' apply.

3. This section determines when this advance directive takes effect. Circle one choice or the other.

4. This section states that your health care agent must make decisions about your care based on the wishes you express in this document or otherwise. If your wishes are unknown, your agent must make decisions based on your best interest.

5. This section states that a person is not financially responsible for your care just because you name him or her as your health care agent.

PART B

This form gives you a choice of stating that you do not want life sustaining treatment if you are near death and there is no hope of your recovery; or that you do want life sustaining treatment for as long as possible, regardless of your condition,

- Circle your choice in Sections 1, 2, and 3 **if you do not want life support.**
- Circle Section 5 **only if you want all possible treatment.**

1. This section directs that if you have a terminal condition, such as cancer, your life should not be extended by using life-sustaining procedures. You must choose whether or not you wish to receive nourishment and fluids through tubes even though you decline other life-sustaining procedures.

2. This section directs that if you are in a persistent vegetative state, such as that caused by severe brain damage, your life should not be extended by life-sustaining procedures. You must choose whether or not you wish to receive nourishment and fluids through tubes even though you decline other life-sustaining procedures.

3. This section directs that if you are in an end-stage condition, such as advanced Alzheimer's Disease, your life should not be extended by life-sustaining procedures. You must choose whether or not you wish to receive nourishment and fluids through tubes even though you decline other life-sustaining procedures.

4. Some drugs given for pain may hasten your death. In this section you must choose whether or not you want these drugs.

5. Circle this section if you want all possible treatment continued even though death is near and there is no hope of your recovery. DO NOT circle this section if you have circled Sections 1, 2, or 3.

6. In this section, add any additional instructions you have, such as your wishes about the donation of your organs after death, the amputations of limbs, or the use of kidney dialysis.

Signature section: Sign the document in the presence of two witnesses. At least one of the witnesses should be a person who will not benefit financially from your death.

AFTER YOU COMPLETE THIS DOCUMENT, GIVE COPIES TO:

- **Health Care Agent**
- **Primary Care Physician**
- **Other Physicians - "This includes Specialist and Referrals"**
- **Registration agent upon admission to a health care facility -**
  At Peninsula Regional Medical Center your Advance Directive will become a part of your permanent medical record. Please notify Peninsula Regional Medical Center, 410-543-7157 if you make changes to your Advance Directive.
- **Other persons involved in your health care decisions**
- **Keep the original at home for yourself, but <u>NOT</u> in a safe deposit box.**

ADVANCE DIRECTIVE FOR HEALTH CARE

I, _____
(name)

residing at _____
(address)

_____ _____

_____ _____ Male ☐ Female ☐
(birthdate) (social security #)

_____
(phone number)

make the following advance directive for health care:

PART A
APPOINTMENT OF HEALTH CARE AGENT

Fill our this part of the form if you want to appoint a health care agent to make health care decisions for you. Cross through this part if you do not want to appoint an agent, or if any items on the form do not apply.

1. I appoint the following individual as my agent to make health care decisions for me:

_____

_____

(Full name, address and telephone number of agent)

Optional: If this agent is unavailable or is unable or unwilling to act as my agent, then I appoint the following person to act in this capacity:

_____

_____

(Full name, address and telephone number of alternate agent)

PART A
APPOINTMENT OF HEALTH CARE AGENT
continued

2. My agent has full power and authority to make health care decisions for me, including the power to

   A. Request, receive and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and consent to disclosure of this information;

   B. Employ and discharge my health care providers;

   C. Authorize my admission or discharge from any hospital, hospice, nursing home, adult home or other medical care facility; and

   D. Consent to the provision, withholding, or withdrawal of health care, including, in appropriate circumstances, life-sustaining procedures.

3. My agent's authority begins:

(CIRCLE the one option that applies)

When two physicians determine that I am incapable of making an informed decision regarding my health care:

OR

When this document is signed.

4. My agent is to make health care decisions for me based on the health care instructions I give in this document or on my wishes as otherwise known to my agent. If my wishes are unknown or unclear, my agent is to make health care decisions for me, with these decisions determined by my agent after considering the benefits, burdens and risks that might result from a given treatment or course of treatment or from the withholding or withdrawal of a treatment or course of treatment.

5. My agent shall not be liable for the costs of care based solely on this authorization.

PART B
HEALTH CARE INSTRUCTIONS

Fill out this part of the form if you want to give specific instructions about your health care.

If I am incapable of making an informed decision regarding my health care, I direct my health care providers, and my agent to follow my instructions as set forth below.

1. If my death from a terminal condition is imminent and even if life-sustaining procedures are used there is no reasonable expectation of my recovery:

(CIRCLE the one option that applies)

I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

OR

I direct that my life not be extended by life-sustaining procedures, except that, if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially,

PART B
HEALTH CARE INSTRUCTIONS
continued

2. If I am in a persistent vegetative state, that is, if I am not conscious and am not aware of my environment nor able to interact with others, and there is no reasonable expectation of recovery:

(CIRCLE the one option that applies)

I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

OR

I direct that my life not be extended by life-sustaining procedures, except that, if I am unable to take food by mouth, I wish to receive nutrition and hydration artificially.

3. If I have an end-stage condition, that is, a condition caused by injury, disease or illness, as a result of which I have suffered severe and permanent deterioration indicated by incompetency and complete physical dependency and for which, to a reasonable degree of medical certainty, treatment of the irreversible condition would be medically ineffective:

(CIRCLE the one option that applies)

I direct that my life not be extended by life-sustaining procedures, including the administration of nutrition and hydration artificially.

OR

I direct that my life not be extended by life-sustaining procedures, except that, if I am unable to take food and water by mouth, I wish to receive nutrition and hydration artificially.

PART B
HEALTH CARE INSTRUCTIONS
continued

4. **(CIRCLE the one option that applies)**

I direct that, no matter what my condition, medication to relieve pain and suffering be given to me even if the medication would shorten my life.

OR

I direct that, no matter what my condition, medication to relieve pain and suffering not be given to me if the medication would shorten my life,

5. **(CIRCLE <u>ONLY</u> if you want treatment continued in all possible circumstances. DO NOT circle if you have circled Sections 1, 2, or 3 above)**

I direct that, no matter what my condition, I be given all available medical treatment in accordance with accepted medical standards.

6. I direct (in the following space, indicate your other instructions regarding provision or withholding of any health care):

_____

_____

_____

By signing below, I indicate that I am emotionally and mentally competent to make this Advance Directive and that I understand the purpose and effect of this document.

_____ _____

(Date/Time) *(Signature of Declarant)*

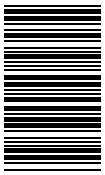
The declarant signed or acknowledged signing these health care instructions in my presence, and based upon my personal observation, appears to be a competent individual.

_____ _____

Signature of Witness Date/Time *Signature of Witness Date/Time*

_____ _____

Address *Address*



ORGAN DONATION ADDENDUM

Prepared by the State of Maryland Office of the Attorney General

(Note: If you want to be an organ donor, you can attach this page to your living will or advance directive. Sign it and have it witnessed.)

I direct that if I am brain dead, an anatomical gift be offered on- my behalf to a patient in need of an organ or tissue transplant. If a transplant occurs, I want artificial heart/lung support devices to be continued on my behalf only until organ or tissue suitability of the patient is confirmed and organ or tissue recovery has taken place.

By signing below, I indicate that I am emotionally and mentally competent to make this organ donation addendum and that I understand the purpose and effect of this document.

_____ _____

Date *Signature of Declarant*

The declarant signed or acknowledged signing this organ donation addendum in my presence and based upon my personal observation, appears to be a competent individual.

_____ _____

Witness *Date*

_____ _____

Witness *Date*

(Signature of two witnesses)

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