

ADVANCE HEALTH CARE DIRECTIVE
ANSWERS FOR _____

Powers of Attorney for Health Care

Agents:

Name: _____

Address: _____

Telephone Number: _____

Name: _____

Address: _____

Telephone Number: _____

Name: _____

Address: _____

Telephone Number: _____

Immediately Effective, or Springing

My agent's powers should be effective immediately, as you recommend
 only upon my incapacity

Organ and Tissue Donation

My agent is *not* authorized to make anatomical gifts (gifts of my body parts), upon my death.

ALTERNATIVELY:

I wish to be an organ and tissue donor, upon my death.

I wish to limit my donation as follows:

I give my body to be used for research by a medical hospital, accredited medical school or dental school, or by a university.

Any particular institution? _____

I give any part for transplant or therapy.

- I give only the following parts for transplant or therapy:

- I do not wish to limit the donation of my body or any parts. My agent has full authority to make these decisions, after I die.

Disposition of Remains

- I have a pre-need contract with a mortuary or cremation service.

Please provide details: _____

- My agent may direct the disposition of my remains.

Autopsy

- I am opposed to autopsies and my agent shall not have the power to grant an autopsy except in those circumstances in which they are required by law.

- My agent may authorize an autopsy.

Primary Care Physician

- I wish to designate my primary care physician as follows:

Name: _____

Address: _____

Telephone Number: _____

- I wish to allow my agent to select a primary care physician for me.

Individual Health Care Instructions

Powers of Attorney, Only

I do not want to leave individual health care instructions. Instead, I will discuss with my agents various end-of-life scenarios and my wishes should my agents need to make decisions on my behalf.

If the above is true, check here and **DO NOT COMPLETE** the rest of the form.

Written Instructions: Option ONE

If you would like to leave individual health care instructions *that would allow your doctors to withhold or withdraw treatment*, please read the following and check the box next to the statement that best describes your wishes.

If I am in an irreversible coma or persistent vegetative state,

- I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued
- At all times, I should be given treatment to alleviate pain or discomfort, even if the treatment hastens my death. I wish to receive any forms of palliative care that may ease my suffering.
- The above also would be true if I were terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death, or if the burdens of treatment would outweigh the expected benefits.

Written Instructions: Option TWO

Option TWO is inconsistent with Option ONE; choose either option, but not both options.

If you would like to leave individual health care instructions *that would prolong or sustain your life*, please read the following and check the box next to the statement that best describes your wishes.

I want to live as long as possible; therefore, I want to receive all medical treatment that will prolong and sustain my life within the limits of generally accepted health care standards. I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment.

EITHER:

- The above statement is true, however at all times, I should be given treatment to alleviate pain or discomfort, even if the treatment hastens my death. I wish to receive any forms of palliative care that may ease my suffering.

OR:

- The above statement is true and I would not want any treatment that might hasten my death, even if I were in pain.

Written Instructions: In Your Own Words

If you would like to add additional instructions to your health care directive, written in your own words, please provide us with those instructions