Vermont Advance Directive for Health Care

Prepared by the Vermont Ethics Network, July 2011

Explanation & Instructions

You have the right to:

1. Name someone else to make health care decisions for you when or if you are unable to make them yourself.
2. Give instructions about what types of health care you want or do not want.

It is important to talk with those people closest to you and with your health care providers about your goals, wishes and preferences for treatment.

You may use this form in its entirety or you may use any part of it. For example, if you only want to choose an agent in Part One, you may fill out just that section and then go to Part Five to sign in the presence of appropriate witnesses.

You are free to use another form so long as it is properly witnessed. More detailed forms providing greater options and information regarding mental health care preference can be found on the VEN website at www.vtethicsnetwork.org.

Part ONE of this form allows you to name a person as your **"agent"** to make health care decisions for you if you become unable or unwilling to make your own decisions. You may also name alternate agents. You should choose someone you trust, who will be comfortable making what might be hard decisions on your behalf. They should be guided by your values in making choices for you **and agree** to act as your agent. You may fill out the Advance Directive form stating your medical preferences *even if you do not identify an agent*. Medical providers will follow your directions in the Advance Directive without an agent to their best ability, but having a person designated as your agent to make decisions for you will help medical providers and those who care for you make the best decisions in situations that may not have been detailed in your Advance Directive. According to Vermont law, next-of-kin will not automatially make decisions on your behalf if you are unable to do so. That is why it is best to appoint someone of your choosing in advance.

Part TWO of this form lets you state **Treatment Goals & Wishes.** Choices are provided for you to express your wishes about having, not having, or stopping treatment under certain circumstances. Space is also provided for you to write out any additional or specific wishes based on your values, health condition or beliefs.

Part THREE of this form lets you express your wishes about **Limitations of Treatment**. These treatments include CPR, breathing machines, feeding tubes, and antibiotics. There is space for you to write any additional wishes. NOTE: If you DO NOT want CPR, a breathing machine, a feeding tube, or antibiotics, please discuss this with your doctor, who can complete a **DNR/COLST order** (Do Not Resuscitate/ Clinician Order for Life Sustaining Treatment) to ensure that you do not receive treatments you do not want, especially in an emergency. Emergency Medical Personnel are required to provide you with life-saving

treatment unless they have a signed DNR/COLST order specifying some limitation of treatment. If there is no DNR/COLST order the emergency medical team will perform CPR as they will not have time to consult an Advance Directive, your family, agent, or physician.

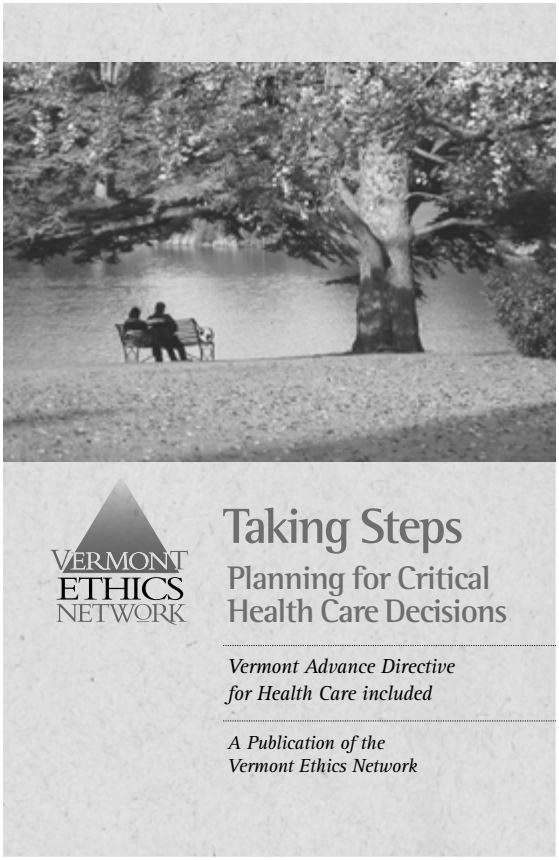
Part FOUR of this form allows you to express your wishes related to **organ/tissue donation & preferences for funeral, burial and disposition** of your remains.

Part FIVE is for **signatures**. You must sign and date the form in the presence of two adult witnesses. The following persons may not be witnesses: your agent and alternate agents; your spouse or partner; parents; siblings; reciprocal beneficiary; children or grandchildren.

You should give copies of the completed form to your agent and alternate agent(s), to your physician, your family and to any health care facility where you reside or at which you are likely to receive care. Please note who has a copy of your Advance Directive so it may be updated if your preferences change.

You are also encouraged to send a copy of your Advance Directive to the Vermont Advance Directive Registry with the Registration Agreement Form found at the end of this document.

You have the right to revoke all or part of this Advance Directive for Health Care or replace this form at any time. If you do revoke it, all old copies should be destroyed. If you make changes and have sent a copy of your original document to the Vermont Advance Directive Registry, be sure to send them a new copy or a notification of change form with information needed to update your Advance Directive there.



You may wish to read the booklet *Taking Steps* to help you think about and discuss different choices and situations with your agent(s) or loved ones.

Copies of *Taking Steps* can be purchased from:

Vermont Ethics Network
61 Elm Street
Montpelier, VT 05602.
Tel: (802) 828-2909
Fax: (802) 828-2646

www.vtethicsnetwork.org

For information about the Vermont Advance Directive Registry visit:

VEN website: www.vtethicsnetwork.org

or

Registry website at the Vermont Department of Health: www.healthvermont.gov/vadr

Vermont Advance Directive for Health Care

YOUR NAME _____ DATE OF BIRTH _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

Part One: Your Health Care Agent

Your health care agent can make health care decisions for you when you are unable or unwilling to make decisions for yourself. You should pick someone that you trust, who understands your wishes and *agrees* to act as your agent.

I appoint this person to be my health care AGENT:

NAME _____

ADDRESS _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ EMAIL _____

(If you appoint co-agents, list them above or on a separate sheet of paper)

If this agent is unavailable, unwilling or unable to act as my agent, I appoint this person as my **alternate agent**:

NAME _____

ADDRESS: _____

HOME PHONE _____ WORK PHONE _____

CELL PHONE _____ EMAIL _____

Others who can be consulted about medical decisions on my behalf include:

Primary care provider(s):

NAME _____ PHONE _____

ADDRESS _____

NAME _____ PHONE _____

ADDRESS _____

(PART ONE CONTINUED NEXT PAGE)

NAME _____ DOB _____ DATE _____

Those who should *NOT* be consulted include:

I want my Advance Directive to start:

- ○ When I cannot make my own decisions
- ○ Now
- ○ When this happens: _____

Part Two: Health Care Goals and Spiritual Wishes

My overall health care goals include:

- ○ I want to have my life sustained as long as possible by any medical means.
- ○ I want treatment to sustain my life only if I will:
  - ☐ be able to communicate with friends and family.
  - ☐ be able to care for myself.
  - ☐ live without incapacitating pain.
  - ☐ be conscious and aware of my surroundings.
- ○ I only want treatment directed toward my comfort.

Additional Goals, Wishes, or Beliefs I wish to express include:

People to notify if I have a life-threatening illness:

If I am dying it is important for me to be (check choice):

- ○ At home
- ○ In the hospital
- ○ Other: _____
- ○ No preference

My Spiritual Care Wishes include:

My Religion/Faith:_____

PLACE OF WORSHIP _____ PHONE _____

ADDRESS _____

_____

The following items or music or readings would be a comfort to me:

_____

NAME _____ DOB _____ DATE _____

PART THREE: LIMITATIONS OF TREATMENT

You can decide what kind of treatment you want or do not want at the end of your life. These wishes can apply to all situations or to situations that you specify. Regardless of the treatment limitations stated you have the right to adequate management for pain and other symptoms (nausea, fatigue, shortness of breath) related to your illness. Unless treatment limitations are stated, the medical teams are required and expected to do everything possible to save your life.

1. If my heart stops: (choose one)

- ○ I DO want CPR done to try to restart my heart.
- ○ I DON'T want CPR done to try to restart my heart.

CPR means cardio (heart)-pulmonary (lung) resuscitation, including vigorous compressions of the chest, use of electrical stimulation, medications to support or restore heart function, and rescue breaths (forcing air into your lungs).

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2. If I am unable to breathe on my own: (choose one)

- ○ I DO want a breathing machine without any time limit.
- ○ I want to have a breathing machine for a short time to see if I will survive or get better.
- ○ I DO NOT want a breathing machine for ANY length of time.

"Breathing machine" refers to a device that mechanically moves air into and out of your lungs such as a ventilator.

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3. If I am unable to swallow enough food or water to stay alive: (choose one)

- ○ I DO want a feeding tube without any time limits
- ○ I want to have a feeding tube for a short time to see if I will survive or get better.
- ○ I DO NOT want a feeding tube for any length of time.

NOTE: If you are being treated in another state your agent may not automatically have the authority to withhold or withdraw a feeding tube. If you wish to have your agent decide about feeding tubes please check the box below.

☐ I authorize my agent to make decisions about feeding tubes.

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4. If I am terminally ill or so ill that I am unlikely to get better: (choose one)

- ○ I DO want antibiotics or other medication to fight infection.
- ○ I DON'T want antibiotics or other medication to fight infection.

If you have stated you DO NOT want CPR, a breathing machine, a feeding tube, or antibiotics under any circumstances, please discuss this with your doctor who can complete a DNR/COLST form to ensure you don't receive treatments you don't want, particularly in an emergency situation. A DNR/COLST order will be honored outside of the hospital setting.

(PART THREE CONTINUED NEXT PAGE)

NAME _____ DOB _____ DATE _____

Additional Limitations of Treatment I wish to include:

Part Four: Organ/Tissue Donation & Burial/Disposition Of Remains

My wishes for organ & tissue donation (check your choice(s)):

☐ I consent to donate the following organs & tissues:

- ☐ Any needed organs
- ☐ Any needed tissue (skin, bone, cornea)
- ☐ I do not wish to donate the following organs and tissues: _____
- ☐ I do not want to donate any organs or tissues
- ☐ I want my health care agent to decide

☐ I wish to donate my body to research or educational program(s). *(Note: you will have to make your own arrangements with a medical school or other program in advance.)*

My Directions for Burial/Disposition of My Remains after I Die (please check & complete):

☐ I have a Pre-Need Contract for Funeral Arrangements:

NAME _____ PHONE _____

ADDRESS _____

I want the following individuals to decide about my burial or disposition of my remains (check choices):

☐ Agent

☐ Alternate Agent

☐ Family:

NAME _____ PHONE _____

ADDRESS _____

☐ Other:

NAME _____ PHONE _____

ADDRESS _____

Specific Wishes: Check your choice(s).

☐ I want a Wake/Viewing

☐ I prefer a Burial — If possible at the following location: (cemetery, address, phone number)

_____

☐ I prefer Cremation — With my ashes kept or scattered as follows:

_____

(PART FOUR CONTINUED NEXT PAGE)

NAME _____ DOB _____ DATE _____

☐ I want a Funeral Ceremony with a burial or cremation to follow

☐ I prefer only a Graveside Ceremony

☐ I prefer only a Memorial Ceremony with burial or cremation preceding

☐ Other Details: (such as music, readings, Officiant)

Part Five: Signed Declaration of Wishes

You must sign this before TWO adult witnesses. The following people may **not** sign as witnesses: your agent(s), spouse, reciprocal beneficiary, parents, siblings, children or grandchildren.

I declare that this document reflects my health care wishes and that I am signing this Advance Directive of my own free will.

SIGNED _____ DATE _____

I affirm that the signer appeared to understand the nature of this advance directive and to be free from duress or undue influence at the time this was signed. *(Please sign and print)*

FIRST WITNESS (PRINT NAME)_____

SIGNATURE _____ DATE_____

ADDRESS _____

SECOND WITNESS (PRINT NAME)_____

SIGNATURE _____ DATE_____

ADDRESS _____

If the person signing this document is a current patient or resident in a hospital, nursing home or residential care home, an additional person (designated hospital explainer, long-term care ombudsman, member of the clergy, Vermont attorney, or person designated by the probate court) needs to confirm below that he or she has explained the nature and effect of the Advance Directive and that the patient or resident appears to understand this.

NAME _____ DATE _____

TITLE / POSITION _____ PHONE_____

ADDRESS _____

NAME _____ DOB _____ DATE _____

The following have a copy of my Advance Directive (please check):

☐ Vermont Advance Directive Registry Date registered: _____

☐ Health care agent

☐ Alternate health care agent

☐ Doctor/Provider(s): _____

☐ Hospital(s): _____

☐ Family Member(s): Please list:

NAME _____

ADDRESS _____

NAME _____

ADDRESS _____

NAME _____

ADDRESS _____

NAME _____

ADDRESS _____

NAME _____

ADDRESS _____

NAME _____

ADDRESS _____

NAME _____

ADDRESS _____

☐ Other:

NAME _____

ADDRESS _____

NAME _____

ADDRESS _____

NAME _____

ADDRESS _____