


Advance Directives Guide

Step-by-Step Instructions: Filling Out Advance Directives Forms

Filling out a designation of health care surrogate form or living will can be intimidating. We're here to help you. The BayCare advance directive form is designed as a single form that allows you to complete the designation of health care surrogate portion, the living will portion, or both.

- 1 Name declaration:** In this area, to complete either the designation of health care surrogate or living will, you must fill out your legal name.
- 2 Surrogate authority:** In this area, the person filling out this form may decide when he or she wishes to have a health care surrogate receive health information or make health care decisions. Initialing in either box isn't required unless you want that action to occur.
- 3 Naming a health care surrogate:** In this area, you provide the information for your health care surrogate. This is the person who you trust to honor your health care wishes. It's recommended that an alternate be designated, if possible.
- 4 Other instructions:** This area allows for additional instructions to be written into the form.

 **MY ADVANCED DIRECTIVE** BayCare.org/AdvanceDirectives

DESIGNATION OF HEALTH CARE SURROGATE

I, (NAME) **1** _____, want to choose how I will be treated by my health care team.

INSTRUCTIONS FOR MY HEALTH CARE SURROGATE
If I am unable to communicate or make my medical decisions, my health care surrogate (HCS) will:

- Talk to my health care team and have access to my medical information
- Authorize my treatment or have treatment stopped based on my choices and values
- Authorize transportation to another facility if needed
- Make decisions about organ/tissue donation based on my choices
- Apply for public benefits, such as Medicare/Medicaid, on my behalf
- Ensure my comfort and management of my pain
- Involve palliative care as a way to ensure my comfort
- Honor my written or oral wishes for end-of-life as designated in my living will

My health care surrogate's authority only begins when my doctor decides that I am unable to make my own health care decisions, UNLESS I initial either or both of the following boxes:

2 _____ My health care surrogate can receive my health information immediately.
_____ My health care surrogate can make health care decisions immediately.

If I am able to make decisions and disagree with any choices made by my health care surrogate, MY choices will be honored. I designate as my health care surrogate:

3 Name _____ Phone _____
Address _____

If my health care surrogate is not willing, able or reasonably available to perform his or her duties, I designate as my alternate health care surrogate:

Name _____ Phone _____
Address _____

4 Other instructions:

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LIVING WILL

I understand that this living will becomes effective only when I am no longer able to communicate or I am not able to make my health care decisions AND when two physicians have determined that I have one of the following:

- A terminal or end-stage condition, and there is little or no chance of recovery
- A condition of permanent and irreversible unconsciousness, such as coma or vegetative state
- An irreversible and severe mental or physical illness that prevents me from communicating with others, recognizing my family and friends, or caring for myself in any way

5 Initial here if you choose not to complete the living will portion of this form at this time.

My specific choices, if I have one of the above conditions	(Please circle the option you prefer)	
Cardiopulmonary resuscitation (CPR) if my heart or breathing stops	YES, I want	No, I do not want
A breathing machine if I am unable to breathe on my own	YES, I want	No, I do not want
Nutrition and fluids through tubes in my veins, nose or stomach	YES, I want	No, I do not want
Kidney dialysis, a pacemaker or defibrillator, or other such machines	YES, I want	No, I do not want
Surgery or admission to a hospital Intensive Care Unit	YES, I want	No, I do not want
Medications that can prolong my dying, such as antibiotics	YES, I want	No, I do not want
Palliative care provided to relieve pain, symptoms and stresses	YES, I want	No, I do not want
Hospice involved in my care at the earliest opportunity	YES, I want	No, I do not want

6 _____

7 _____

Make It Legal: (Your health care surrogate(s) cannot serve as a witness to this document. At least one witness must be someone other than your spouse or a blood relative.)

8 I fully understand the meaning of this form; I am emotionally and mentally competent to make decisions listed in this form and have given these decisions careful thought.

Your signature _____ Print name _____ Date _____ Time _____

Witnessed by:

First witness signature _____ Print name _____ Date _____ Time _____

First witness address _____ City _____ State _____ Zip _____

Second witness signature _____ Print name _____ Date _____ Time _____

Second witness address _____ City _____ State _____ Zip _____

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5 Living will consent: This area contains information related to the completion of the living will portion of the form only, and isn't required if you only want to designate a health care surrogate. If you don't want to complete the living will portion, initialing the box is required.

6 Identifying specific choices: In this section, you can choose to designate some or all of the health care you'd like if the living will goes into effect.

7 Optional information: In this area, you can express any additional thoughts or concerns, such as quality of life or personal beliefs. This area isn't required.

8 Form completion: In order for the designation of health care surrogate form and/or the living will form to be valid, it must be signed, along with the date and time. Additionally, two witnesses must also sign the form, also with the date and time. Your health care surrogate or surrogate alternate can't sign the form, and at least one witness must be someone other than your spouse or a blood relative.

