HEALTH CARE LIVING WILL

This is my Health Care Living Will. My name is ________________________________
(print full name)

There are two parts of this document. In Part 1, you choose someone to be your medical decision maker (this person/"agent" has an ETHICAL DUTY to honor your values and wishes). In Part 2, you specifically express your values and wishes about health care.

NOTE: You don't have to complete both parts of the Living Will but it is optimal if you do. This helps guide physicians to give you the type of medical care that is in accordance with your wishes when you are critically ill and you can't communicate.

Part 1: POWER OF ATTORNEY FOR HEALTH CARE
(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

____ __________________________
(print name of individual you choose as agent) (relationship to you)

____
(address, city, state, post code, country)

____
(home phone) (work phone) (mobile phone)

OPTIONAL: If I revoke (take away) my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

____ __________________________
(print name of individual you choose as agent) (relationship to you)

____
(address, city, state, post code, country)

____
(home phone) (work phone) (mobile phone)

NOTE: You don't have to appoint an alternate agent but it is highly recommended (in case your primary agent moves and cannot be located, dies, is too ill to participate, or is otherwise unable or unwilling to be your decision-maker).

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OPTIONAL: If I revoke (take away) the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

____ _________________________

(print name of individual you choose as agent) (relationship to you)

____

(address, city, state, post code, country)

____

(home phone) (work phone) (mobile phone)

NOTE: You can change who you appoint to be your agent at any time. Also, it is VERY important to inform your agent that you have appointed him/her to be your surrogate decision maker for health care matters. You should discuss your Living Will with your primary and alternate agents to ensure that they understand your values and wishes, and to confirm that they are willing to honor your desires. If they indicate they cannot, you should appoint a different person(s) to be your agent(s).

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

____
____
____
____
____

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when the medical team determines that I am unable to make my own health care decisions unless I indicate below.
If I initial this line ______ , my agent's authority to make health care decisions for me takes effect immediately.

(1.4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be <u>in my best interest</u>. In determining my best interest, my agent shall consider <u>my personal values</u> to the extent known to my agent.

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(1.5) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

Part 2: INSTRUCTIONS FOR HEALTH CARE

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have selected below (insert initials on either line a or b):

_____(a) Choice Not To Prolong Life
I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

_____(b) Choice To Prolong Life
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

NOTE: Physicians have no ethical or legal duty to provide futile medical interventions (even if patients or agents/family demand them). Futile interventions are procedures, services, tests, medications, etc. which are determined to offer you no benefit. Futile interventions can, in fact, be harmful. There are times when dialysis, cardiopulmonary resuscitation (CPR), organ transplant, breathing and feeding tubes, for example, are futile.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

____
____
____
____

(2.3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

____
____
____
____
____
____

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(2.4) SPECIFIC VALUE STATEMENTS: below are some statements about how I feel about life, health, health care, dying, and other related matters. I want these statements reflected upon when decisions are being made about my health care. **(You can complete any, all, or none of these with your own written words).**

With regard to serious illness, my life would be no longer worth living if:

I practice the following religious/spiritual/philosophical beliefs/traditions. This impacts my views about health care and dying as follows:

These are my values about living the remainder of my life in a nursing home:

These are my values about losing my independence and requiring the assistance of others to take care of me for the rest of my life (e.g., bathing, feeding, personal hygiene):

These are my values about artificial feeding and hydration (feeding tubes):

These are my values about a living attached to a breathing machine/ventilator:

These are my values about CPR (cardiopulmonary resuscitation—attempts to revive a stopped heart and/or breathing that has stopped with electric shocks, chest compressions, a breathing tube, medication, etc):

What would you like to say to someone reading this document about your overall attitude toward life?

If possible, I prefer to die at the following location: (circle one)

At home   In a hospital intensive care unit   In a nursing home   Hospice facility

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Part 3: IMPLANTS
I have the following medical implant device(s) inside my body (insert check marks):
____Pacemaker*
____Defibrillator*
____Pacemaker-Defibrillator combination device*
____Ventricular Assist Device*
____Total Artificial Heart*
____Neurostimulator (brain, stomach, bladder, bowel, etc.)
____ITB (intrathecal baclofen) device
____Ascites pump
____Other: ____

NOTE: Referring to Section 2.1a of this document, these implants* are considered forms of artificial life support which would generally be turned off with other forms of life support such as dialysis and breathing machines under certain situations (comfort care/end of life protocols). Also, if you don't have an implant now but receive one in the future, be sure to update your Living Will to reflect this new information (and any change in your values).

Place your initials here _____ if you consent to the removal and analysis of the device after your death. Data obtained from analyzing removed devices can help manufacturers create products to help future patients, and can potentially identify problems with existing products.

If you want the device returned to your family after removal and manufacturer analysis, please initial here____

NOTE: Pacemakers are *always* removed before cremation. Additionally, some jurisdictions *require* battery-operated implants to be removed before cremation <u>or</u> burial due to environmental concerns.

Part 4: DONATION OF ORGANS AT DEATH
(4.1) Upon my death (circle your choice):
(a) I give any needed organs, tissues, or parts, OR
(b) I give the following organs, tissues, or parts only:
____
(list organs, tissues, and/or parts you wish to donate)

(c) My gift is for the following purposes (indicate the ones you want):
(1) Transplant
(2) Therapy
(3) Research
(4) Education
(d) I do NOT wish to be an organ or tissue donor
(e) I wish to donate my entire body for research or education (e.g., Willed Body Program)

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Part 5: Disposition of my body after death
After my death, I desire my body to be (select one):

Cremated   Buried   Other ________________________________

I will/ will not allow an autopsy of my body. (circle one option)

NOTE: Sometimes, the law requires that an autopsy be performed. If you would like a rabbi or other clergy present, please initial here:_______

YOUR SIGNATURE: Sign and date the form here:

____ __________________________
(sign your name) (date)

______________________________ ____
(print your name) (your street address)

____
(city) (state) (post code) (country)

IF YOU ARE A RESIDENT OF QUEENSLAND: It is a requirement of the Powers of Attorney Act 1998 that you sign this document in the presence of a doctor. It is strongly recommended that, before completing this document, you discuss it with your general practitioner or a specialist medical practitioner who knows your medical history and views. The doctor will then be able to explain any medical terms that you are unsure about and will also be able to state that you were not suffering from conditions that would affect your ability to understand the decisions you have made in the document**.**

Doctor's name: ____
Doctor's address:
____
____ Postcode: ________
Doctor's telephone number: ________________________

Statement of the nominated doctor
(a) I have discussed this document with the principal and, in my opinion, he/she is not suffering from any condition that would affect his/her capacity to understand the things necessary to make this directive, and he/she understands the nature and likely effect of the health care described in this document, and

(b) (*check one box only)*
___the principal signed this part of this document in my presence,
___in my presence, the principal instructed another person to sign this part of this for the principal, and the person signed it in my presence and in the presence of the principal,

(c) I am not
- the person witnessing this Advance Health Directive
- or the person signing the Advance Health Directive for the principal
- or an attorney of the principal
- or a relation of the principal or of an attorney of the principal
- or a beneficiary under the principal's will.

________________________ ____________________________
[Principal signs here] [Doctor signs here]

____
[Doctor writes the date here]

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IF YOU ARE A RESIDENT OF QUEENSLAND, one of the following individuals must witness your living will: justice of the peace, commissioner for declarations, lawyer, or notary public.

I, ____ , state that—
[Print your full name here]

(a) I am at least 21 years of age,

(b) I am a
___justice of the peace
___commissioner for declarations
___lawyer
___notary public,

(c) I am not
■ an attorney for the principal
■ or a relation of the principal, or a relation of the principal's attorney (if any)
■ or a beneficiary under the principal's will
■ or a current paid carer or health-care provider for the principal,
Note: 'Paid carer' does not mean someone receiving a carer's pension or similar benefit.

(d) I have verified that the living will has been signed and dated by a doctor.

(e) *(check one box only)*
___the principal signed this directive in my presence
___in my presence, the principal instructed another person to sign for the principal, and the person signed it in my presence and in the presence of the principal,
and
(f) at the time that this directive was signed, the principal appeared to me to understand the concepts and directives in the document.

____
[Witness signs here]

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IF YOU ARE A RESIDENT OF USA (OR ELSEWHERE), HAVE TWO WITNESSES SIGN YOUR LIVING WILL: STATEMENT OF WITNESSES:
I declare under penalty of perjury (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence,(3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First witness	Second witness
________________________________	______________________________________
(print name)	(print name)
________________________________	______________________________________
(address)	(address)
________________________________	______________________________________
(city) (state) (post code)	(city) (state) (post code)
________________________________	______________________________________
(signature of witness)	(signature of witness)
________________________________	______________________________________
(date)	(date)

ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration: I further declare under penalty of perjury that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

____

(signature of witness)

SPECIAL WITNESS FOR SKILLED NURSING HOME PATIENTS: If you are a patient in a skilled nursing facility--a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis-- have the patient advocate or ombudsman sign the following statement:

I declare under penalty of perjury that I am a patient advocate or ombudsman and that I am serving as a witness.

________________________________	______________________________________
(date)	(sign your name)
________________________________	______________________________________
(address)	(print your name)
________________________________	______________________________________
(city) (state) (post code)	(phone number)

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NOTE: Do not keep this valuable document locked away in your safe deposit box (where few people can access it). Please give a copy to your personal physician, your agent and alternate agent(s), and anyone else you think would benefit from knowing its contents. If you know you have a surgery in the near future, bring a copy of this document to the hospital when you check-in and it will be placed in your medical chart. Some hospitals will even place it on file permanently for safe-keeping.

If you update your Living Will, be sure to give the hospital and your agent(s) the current version. If you have time, bring it with you when you go to the Emergency Room also. Keep a copy in the glove box of your car. Keep a copy in your purse/briefcase. You can also store an electronic copy in your digital device such as an iPad, laptop or smartphone.

******This Living Will pertains to HEALTH CARE only, not personal finances******

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