Printed Name: _____ **Birth Month:** _____ **Year:** _____

The Advance Directive and Living Will

Preserve Your Personal Choices

Many people have become aware that medicine today has the ability to keep people alive for extended periods of time. For many, there is concern that their wishes may not be followed in these cases. If you are at least 18 years of age and of sound mind, there is something you can do to make your wishes known. You have the right to execute an Advance Directive and Living Will. This document can speak for you if you are unable to do so for yourself. It gives you a way to tell your wishes to those who need to know. There is no legal requirement to complete an advance directive. However, if you have not made an advance directive or designated a health care surrogate, health care decisions may be made for you by a court-appointed guardian, your spouse, your adult child, your parent, your adult sibling, an adult relative or a close friend (in that order). This person would be called a proxy.

The Advance Directive and Living Will form is a community service project of Martin Health System. If you have any questions about the directive, contact your attorney, physician or clergyman. Additional copies of the form may be obtained by calling the Martin Health Marketing Communications department at 772.223.5911.

MARTIN HEALTH SYSTEM

hope at every turn

Printed Name: _____ **Birth Month:** _____ **Year:** _____

Introduction to the Advance Directive and Living Will

Every competent adult has, in most cases, the freedom to accept or refuse medical treatment. When you are well, you can talk with your physician and family to make your wishes known. However, severe illness or an accident could cause you to be unable to communicate or to make choices. During that time, important decisions about your medical care may have to be made. Without any instructions from you, your family and physicians may not know what treatment you would want.

You can help your family and physicians by telling them, in advance, preferably in writing, what you would want done in certain situations. This planning ahead for future health care decisions is known as an "**Advance Directive**." Your directive goes into effect only if you become unable to make choices or express your wishes. You can change it at any time up until that point, by writing or making an oral statement.

You should also choose a person to act as your Health Care Surrogate to make decisions for you if you are unable to make them for yourself. Your health care surrogate is obligated to make the choices he or she believes you would make if you were able. You may also choose an alternate surrogate. You are encouraged to complete both the directive and the surrogate appointment since not every possible situation is addressed in the directive. Your directive can assist your surrogate in determining what your wishes would be. Choose someone you trust, who understands your wishes and agrees with them.

Before you fill out the Advanced Directive and Living Will form, you may want to talk to your family, friends, physician, lawyer or spiritual advisor. This is not required, however, and the documents do not need to be notarized.

The directive describes three situations and allows you to indicate which treatments you would want or would not want if your physician recommended them. If a situation you are particularly concerned about is not included, you can make additional comments in the section provided.

In many cases, in the situations described, it may take days or even weeks for the prognosis (outlook for recovery) to be established. In the interim, until the outlook is known, some of the treatments listed may be appropriate. Only after the prognosis is known with reasonable medical certainty is it appropriate to withdraw or withhold such treatments. The situations described assume that your physician and at least one consultant share the opinion regarding the outlook for your recovery. The possible treatments are considered only if medically reasonable.

After you complete the form give a copy to your regular physician, your health care surrogate and a trusted family member or friend. If you change your advance directive, make sure they have the latest copy. Carry a copy with you that states the location of the original. If you reside in the Martin Health System service area, we will file a copy in our Medical Records Department under your name. You may mail a copy of this completed form to:

Medical Records Dept.
Martin Health System
P.O. Box 9010
Stuart, FL 34995

ORGAN DONATION

After my death, if any of my organs or tissues would be of value as transplants to help others, I DO / DO NOT instruct my next of kin to authorize such donation.

Other Comments or Instructions:

_____

_____

_____

_____

Date Signature

POLICY

Martin Health System supports the right of every adult to receive adequate information at any point in their care process concerning their health care choice. Patients shall be afforded the opportunity to discuss their choice with their physician and shall be given the opportunity to freely consent to or refuse health care. Martin Health System further supports the right of every adult to express, either verbally or through a written document (advance directive), any wishes they want followed by their substitute decision maker and health care provider should they ever lose their capacity to express those wishes. All adult patients shall be given information about these rights.

If an advance directive is presented, notice will be given to your care providers and a copy will be placed in your medical record.

Portions of this form are reprinted with the permission of the Risk Management Department of Lakeland Regional Medical Center, Inc.

Printed Name: _____ **Birth Month:** _____ **Year:** _____

The Advance Directive and Living Will

If you were in the condition described in the three situations, what would your choice be regarding the possible treatments listed on the left? Mark your choices in the appropriate boxes.

DECLARATION made this _____ day of _____ 20_____. I _____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare:

Possible Treatments Assume none of the following will improve or cure the condition described in the situations.	**Situation A** If I am in a terminal condition, caused by illness or injury, and have no reasonable hope of recovery or of becoming aware of my surroundings or being able to use my mental abilities, then my wishes regarding the following would be:	**Situation B** If I have a progressive illness or end-stage condition that is caused by injury or disease, which has resulted in severe and permanent deterioration or which will continue to worsen and result in my death, and which cannot be improved or cured, and the point is reached that I am no longer able to recognize family and friends or speak understandably, my wishes regarding the following would be:	**Situation C** If I am in a persistent vegetative state or have a condition which makes me unable to recognize people, have voluntary action or thought, or communicate understandably, and that condition is permanent and cannot be improved or cured but is NOT terminal, my wishes regarding following would be:
1. Do you want efforts to be made to resuscitate you (chest massage) if your heart stops beating?	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**
2. If you are unable to breathe on your own, do you want a mechanical breathing machine (respirator) to be used?	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**
3. If your kidneys fail, do you want kidney dialysis (cleaning the blood through a machine)?	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**
4. Do you want any surgery, even if it is life-saving?	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**
5. Do you want pain medications to keep you comfortable even if they dull consciousness and could shorten your life?	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**
6. Do you want other medications, such as antibiotics, which may prolong your life?	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**
7. Do you want food and water given to you through tubes in your veins, nose or stomach?	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**
8. Other:	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**	☐ **YES** ☐ **NO** ☐ **UNDECIDED**

Date _____ Patient Signature _____

Witness* _____ Witness* _____

**Witnesses cannot be spouse, blood relative or surrogate.*

Printed Name: _____ **Birth Month:** _____ **Year:** _____

Designation of Health Care Surrogate

You may choose a person to make medical decisions which may not have been specifically addressed by your Advance Directive and Living Will. This person is called your Health Care Surrogate and if you are unable to make your own decisions, he/she shall have the authority to:

A. Act for you to make health care decisions which he/she believes you would have made under the circumstances if you were able;

B. Consult with appropriate health care providers to provide informed consent in your best interest and give consent in writing on the appropriate forms;

C. Have access to your clinical records and authority to release information and clinical records to appropriate persons to provide continuity of care;

D. Apply for public benefits such as Medicare and Medicaid for you and have access to information about your income and assets and banking and financial records as needed to make the application;

E. Release information and clinical records to appropriate persons; and

F. Authorize the transfer and/or admission of you to or from a health care facility.

Designation of Health Care Surrogate

In the event that I, _____, have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: _____ Phone: _____

Address: _____

If my surrogate is unwilling or unable to perform the duties, I wish to designate as my alternate surrogate:

Name: _____ Phone: _____

Address: _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and authorize my admission to or transfer from a health care facility.

Additional instructions (optional): _____

I authorize my health care providers to disclose my health condition and prognosis to the following persons without requiring any written or oral authorizations from my surrogate: _____

This shall remain effective until I change or revoke this designation.

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

Date _____ Patient Signature _____

Witness* _____ Witness* _____

**Witnesses cannot be spouse, blood relative or surrogate.*