VERMONT ADVANCE DIRECTIVE FOR HEALTH CARE

EXPLANATIONS AND 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 Seven to sign in the presence of appropriate witnesses.

You are free to use another form as long as it is properly signed and witnessed.

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 automatically 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 and 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 lets you express **Other Specific Instructions** about health care preferences such as types of medicines, health care settings, or treatment you may experience.

PART FIVE of this form is a **Waiver of Right to Request or Object to Treatment**. This is a special part that may be used by people who want their future responses to offered health treatment disregarded or ignored. This section is often referred to as the "Ulysses Clause." *You must have an agent to fill out this section and in order to suspend or revoke this section you must have capacity.*

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

PART SEVEN 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, with the exception of Part 5, the Waiver of Right to Request of Object to Treatment. Part 5 may only be suspended or revoked when you have capacity. If you do revoke you Advance Directive, 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.

For assistance completing an Advance Directive contact Disability Rights Vermont, 141 Main Street, Suite 7, Montpelier, VT 05602. Telephone 800-834-7890 or visit www.disabilityrightsvt.org.

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.Telephone (802) 828-2909; 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.