VERMONT ADVANCE DIRECTIVE FOR HEALTH CARE

YOUR NAME _____ DATE OF BIRTH _____DATE_____
ADDRESS_____
CITY_____ STATE_____ ZIP _____
TELEPHONE_____ EMAIL_____

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_____

Those who should *NOT* be consulted include:

I want my Agent to have decision making authority:

- ☐ When I cannot make my own health care decisions
- ☐ Now
- ☐ When this happens: _____

NOTIFICATION: If I am unable to do so myself, I request that facility staff or my agent notify the following individuals immediately that I have been admitted to a health care facility:

PART TWO: OVERALL HEALTH CARE GOALS AND SPIRITUAL WISHES

Goals, wishes or beliefs I wish to express include:

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

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

Spiritual Care

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.

Additional limitations of treatment I wish to include:

PART FOUR: OTHER SPECIFIC INSTRUCTIONS

I prefer the following home or community-based services and facilities as an alternative to hospitalization:

If I need hospitalization or care in a treatment facility, the following facilities are listed in order of preference:

Name_____ Phone _____
(OPTIONAL) I prefer this facility because _____
Name_____ Phone _____
(OPTIONAL) I prefer this facility because _____
_____

Avoid using the following hospitals or treatment facilities:

Name _____ *(OPTIONAL)* Reason to avoid_____
_____
Name _____ *(OPTIONAL)* Reason to avoid_____
_____

Please do the following things that help me reduce my symptoms, make me more comfortable, and keep me safe:

Do not do the following, they will not help and may even make matters worse:

I do not want the following people to visit me while I am in a health care facility:

Pharmacy name and phone:

Allergies:

Medications and Health Care Preparations:

I have the following preferences_____
_____
_____

Use the following medications and health care preparations *only* if all other options have been ruled out as being ineffective by my treating physician:

I <u>do not consent</u> and I <u>do not authorize</u> my agent to consent to the administration of the following medications:

☐ I am aware that the medication decisions I state in this document may result in longer hospital stays and may also result in an Application for Involuntary Treatment being filed or in my being involuntarily committed or treated. I have made my treatment decisions with full awareness of these and other possibilities.

If it is determined that an emergency involuntary procedure must be implemented while I am in a medical facility, I prefer these interventions in the following order. ***List by number only those interventions you prefer.*** For example, 1 = first choice; 2 = second choice, etc.

Medication in pill form

Liquid medication

Medication by injection

Seclusion

Physical Restraint

Manual Restraint

(OPTIONAL) Reason for preferences:

NAME_____DOB_____ DATE_____

Electroconvulsive Therapy

If it is determined that I am not legally capable of consenting to or refusing Electroconvulsive Therapy (ECT or Shock Therapy) my preference is checked below:

☐ I **do not consent** to the administration of ECT.

☐ I **consent** and authorize my agent to consent to the administration of ECT.

Other instructions regarding the administration of ECT:_____

Consent for drug trials, student education or treatment studies

☐ I **consent** or ☐ I **do not consent** to my participation in drug trials, student education or treatment studies.

☐ I **authorize my agent to consent** to my participation in drug trials, student education or treatment studies after consulting with my physician and any individuals my agent thinks appropriate, determines the benefits to me outweigh the risks , and that other, non-experimental interventions are not likely to provide effective treatment.

Guardians (If the Court appoints a Guardian for me):

I wish the following person(s) to be considered as potential guardian(s) for me:_____

_____

I do not wish the following person(s) to be considered as potential guardian(s) for me:_____

_____

Release of Medical Information

If I am ever involuntarily admitted to a health care facility I give permission to that facility and its staff to disclose all information in my medical record (including personal observations, psychiatric treatment, drug or alcohol treatment) to the agent and alternate agent appointed in my Advance Directive. This release is to take effect regardless of my capacity. I also give permission for my agent to authorize release of health care information to the following individual(s):_____

_____

_____

Enforcement Provision

I grant my agent, alternate agent and Disability Rights Vermont the authority to enforce compliance with and implementation of my Advance Directive for Health Care. I further grant them the authority to request an evaluation to determine my ability to make my own health care decisions.

Sign and date if you agree _____

PART SIX: ORGAN/TISSUE DONATION & BURIAL /DISPOSITION OF REMAINS

My wishes for organ and 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:

☐ 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 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: _____
☐ 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)

_____

NAME_____DOB_____ DATE_____

PART SEVEN: SIGNED DECLARATION OF WITNESSES

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.

SIGNATURE _____DATE_____

Acknowledgement of Witnesses

I affirm that the principal 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)*

SIGNATURE_____ DATE_____
FIRST WITNESS (PRINT NAME) _____ TEL _____
ADDRESS_____

SIGNATURE_____ DATE_____
SECOND WITNESS (PRINT NAME) _____ TEL _____
ADDRESS_____

If the person signing this document is being admitted to or is a current patient in a hospital, one of the following must sign and affirm that they have explained the nature and effect of the advance directive and the patient appeared to understand and be free from duress or undue influence at the time of signing: designated hospital explainer, ombudsman, mental health patient representative, recognized member of the clergy, Vermont attorney, or Probate Court designee.

If the person signing this document is being admitted to or is a resident in a nursing home or residential care facility, one of the following must sign and affirm that they have explained the nature and effect of the advance directive and the resident appeared to understand and be free from duress or undue influence at the time of signing: an ombudsman, recognized member of the clergy, Vermont attorney, Probate Court designee, designated hospital explainer, mental health patient representative, clinician not employed by the facility, or appropriately trained nursing home/residential care facility volunteer. The explainer as outlined above may also serve as one of the two required witnesses.

Name: _____ Title/position: _____
Address: _____ Phone: _____
Signature: _____ Date: _____

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

- ☐ Vermont Advance Directive Registry
- ☐ Health Care Agent
- ☐ Alternate Health Care Agent
- ☐ Disability Rights Vermont
- ☐ Doctor/Provider(s):_____
- ☐ _____
- ☐ Hospital(s):_____

_____

_____

_____

☐ Family Member(s) (please list):

NAME_____PHONE _____

ADDRESS_____

NAME_____PHONE _____

ADDRESS_____

NAME_____PHONE _____

ADDRESS_____

If you choose to register your Advance Directive please send a copy along with a completed Registration Agreement form which can be found at the State of **Vermont Department of Health** website http://www.healthvermont.gov/vadr/ to **Vermont Advance Directive Registry**, P.O. Box 2789, Westfield, NJ 07901-2789 or call the Vermont Department of Health toll-free at 1-800-464-4343.

If you have questions or need assistance please contact **Disability Rights Vermont**, 141 Main Street, Suite 7, Montpelier, Vermont, 05602; 1-800-834-7890 toll free or visit us on the web http://www.disabilityrightsvt.org/.