MALE'S ADVANCE HEALTH CARE DIRECTIVE WORKSHEET

PLEASE PROVIDE YOUR NAME:

PLEASE PROVIDE YOUR PARTNER'S NAME, IF APPLICABLE:

The **Advance Health Care Directive (AHCD)** is a legal document that combines two legal documents into one:

A Durable Heath Care Power-of-Attorney: This appoints a "Health Care Agent" with the authority to make medical and health care decisions for you, following your instructions and directions in the AHCD. **The authority only takes effect if you are incapacitated and can no longer direct your own medical and health care.** It also stays in effect as long as you are incapacitated.

A Directive to Doctors: If your Health Care Agents are no longer available to make medical and health care decisions for you, the AHCD also provides guidance for your doctors concerning your wishes for your medical and health care, permitting them to act on those instructions.

As your AHCD is customized for you, this Worksheet contains a series of questions for you to answer to help us craft a document that is unique for you and covers everything that is of concern to you. There are no "right" or "wrong" answers. With that in mind, let's begin.

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WHEN DO YOU WANT YOUR ADVANCE HEALTH CARE DIRECTIVE TO BE IN EFFECT?

☐ **Option #1: When two doctors have examined you**

Your Advance Health Care Directive will take effect and your Health Care Agent will be in charge only after two doctors have personally examined you and certified in writing that you are unable to make or communicate decisions regarding your affairs. If you have designated a primary doctor or alternate primary doctor in your Advance Health Care Directive, then one of the doctors should be your primary doctor or alternate primary doctor if reasonably available.

☐ **Option #2: Immediately on the day you sign the Advance Health Care Directive:**

This is appropriate if you are going in for surgery for or other medical procedures, or are suffering from a current medical condition, and you anticipate that you will be or may be incapacitated for some time.

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SELECTING YOUR HEALTH CARE AGENTS

Please identify those people you wish to act as your Health Care Agents. Please fill in the information requested below for each Health Care Agent below, in the order you wish for them to serve.

First Agent Name:					
Relationship to you:					
Full Address:			Email Address:		
Home Phone		Work Phone		Cell Phone	

Second Agent Name:					
Relationship to you:					
Full Address:			Email Address:		
Home Phone		Work Phone		Cell Phone	

Third Agent Name:					
Relationship to you:					
Full Address:			Email Address:		
Home Phone		Work Phone		Cell Phone	

Fourth Agent Name:					
Relationship to you:					
Full Address:			Email Address:		
Home Phone		Work Phone		Cell Phone	

JOINT HEALTH CARE AGENTS

Do you want to have any of your Health Care Agents to serve together at the same time? ☐ YES ☐ NO If you answered "YES," write in the names of the Health Care Agents you want to serve together

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JOINT HEALTH CARE AGENTS WHO CAN ACT INDEPENDENTLY

If you have named any of your Health Care Agents to serve as **Joint Health Care Agents** as noted in the last section on the previous page, they will have to make decisions jointly as a group. However, if you wish to have one or more of your **Joint Health Care Agents** to have the right to act independently from your other Health Care Agents, you may list those Agents who may act independently here:

COMPENSATION FOR YOUR HEALTH CARE AGENTS

☐ I want my Health Care Agents to be reimbursed for any expenses they have while acting as my Health Care Agent.

☐ I want my Health Care Agents to receive reasonable compensation while acting as my Health Care Agents

NOMINATION OF CONSERVATOR (if needed)

Although it is rare for a Conservator to be appointed by a Court when you have proper estate planning documents in place, it can happen. If a Conservator (i.e. guardian) needs to be appointed by a Court for you, please select who you wish to act as your Conservator:

☐ I want my Health Care Agents to be appointed as my Conservator in the order stated on the previous page

☐ I want the following person(s) to be appointed as my Conservator in the order named:

First Conservator Name:					
Relationship to you:					
Full Address:					
Home Phone		Work Phone		Cell Phone	

Second Conservator Name:					
Relationship to you:					
Full Address:					
Home Phone		Work Phone		Cell Phone	

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DESIGNATION OF PRIMARY DOCTOR AND/OR ALTERNATE DOCTOR (optional)

If you have a doctor that you believe knows you and your medical condition well, and you would want that doctor involved in consultations about your medical care, then you should provide information about that doctor here.

☐ **Option #1:** I do not wish to designate a **Primary Doctor**.

☐ **Option #2:** I wish to designate a Primary Doctor

(Option #2 - Provide information on Doctor or Medical Group)

Name	
Address	
City, State, Zip code	
Telephone Number(s)	

☐ **Option #1:** I do not wish to designate an **Alternate Primary Doctor**

☐ **Option #2:** I wish to designate an Alternate Primary Doctor if my Primary Doctor is unavailable

(Option #2 - Provide information on Doctor or Medical Group)

Name	
Address	
City, State, Zip code	
Telephone Number(s)	

The following additional language will also be inserted into your Advance Health Care Directive

"I hereby authorize my Health Care Agent to select any attending doctor of mine as my primary doctor if I have not designated a primary doctor, or if my primary doctor and any alternate primary doctor cannot attend to my medical care."

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The rest of this Advance Health Care Directive Worksheet deals with your specific wishes concerning medical treatments and procedures, end-of-life decisions, instructions to your health care agents, and directives to your doctors about your care.

NOTE: Your instructions and directives will not have any legal effect while you are still able to direct your own medical care and make your own decisions about your health care. Only if you become incapacitated will these instructions and directives be in effect.

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OPTIONS CONCERNING WITHHOLDING MEDICAL TREATMENTS AND PROCEDURES

Please select <u>one</u> of the following options:

☐ **Option #1 - "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."** *[This is the most common choice of my clients. It recognizes that if you have various illnesses or medical conditions, there may be times when you would want to have life-sustaining procedures discontinued.* ***<u>If you selected this option, then finish the remainder of this Worksheet, paying special attention to the sections marked with a ¥¥¥ symbol (a "Triggering Condition"</u>.***

☐ **Option #2 - "Choice To Prolong Life: I want my life to be prolonged as long as possible within the limits of generally accepted health care standards."** *[This is the least common choice of my clients. Selecting this option means that you wish for every effort to be made that is medically possible to keep you alive, regardless of your medical circumstances.* ***<u>If you selected this option, then finish the remainder of the Worksheet, ignoring any section that is labeled with a ¥¥¥ symbol</u>.]***

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PAIN CONTROL OPTIONS

Drugs, or surgical or medical procedures

☐ "I wish to have pain-relieving drugs of any type administered, or other surgical or medical procedures calculated to alleviate my pain. Such pain relief may be authorized even though their use may lead to physical damage, addiction, or even hasten the moment of (but not intentionally cause) my death." **OR**

☐ "I do not authorize pain-relieving drugs of any type to be administered to me, or other surgical or medical procedures calculated to alleviate my pain."

"Unconventional" pain-relief therapies"

☐ "I consent to the arrangement for unconventional pain-relief therapies such as biofeedback, guided imagery, relaxation therapy, acupuncture, and other therapies which my Health Care Agent believes may be helpful to me." **OR**

☐ "I do not consent to unconventional pain-relief therapies such as biofeedback, guided imagery, relaxation therapy, acupuncture, and other therapies."

¥¥¥ DO NOT RESUSCITATE ORDER ("DNR")

This is a specific directive to a health care provider that, in the event you should stop breathing, have a heart attack, or otherwise "die," you direct your health care provider to take no action to revive you or otherwise try to bring you back to life. This is also sometimes called "extraordinary measures" or "Code Blue" on the medical shows.

☐ "If there has been a Triggering Condition, I give my express consent for a DO NOT RESUSCITATE (DNR) order, and I specifically direct that a DO NOT RESUSCITATE (DNR) order be placed into my medical records. Additionally, if my death is imminent, I wish to have a DO NOT RESUSCITATE (DNR) order effective immediately." **OR**

☐ "I do not consent to a DO NOT RESUSCITATE (DNR) order being placed into your medical records, even if there has been a Triggering Condition, and even if my death is imminent."

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ALLERGIES

If you are allergic to various drugs, foods or other substances, please indicate below. Please also write in other allergies you may have, especially if they are life-threatening.

☐ I have no known allergies; **OR**

☐ I have the following known allergies:

☐ Sulfa ☐ Penicillin ☐ Milk products ☐ Wheat ☐ Bee/Wasp stings

☐ Other:	
☐ Other:	
☐ Other:	

¥¥¥ TREATMENT FOR PRE-EXISTING OR FUTURE MEDICAL CONDITIONS

☐ I have no known pre-existing medical conditions; **OR**

☐ I have the following pre-existing medical conditions being treated with the following medications or treatments:

Medical Condition	**Medications or Treatment**

☐ "I generally wish to have any medications or treatments continued for any pre-existing of mine or future medical conditions I may have if I am ill. However, if there has been a Triggering Condition and I am receiving medications or treatments that could be interpreted as "life-sustaining," I wish to have those medications or treatments discontinued. OR

☐ "I wish to have any medications or treatments for any pre-existing or future medical conditions continued, even if there has been a "Triggering Condition, and even if the medications and/or treatments could be interpreted as "life-sustaining."

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¥¥¥ - ANTIBIOTICS

This option deals with the use of antibiotics to treat infections. Regardless of your choice here, your Advance Health Care Directive will grant authority to your health care providers to use antibiotics to prevent the spread of any contagious infection so that others are not infected.

Urinary tract infections will be treated only with oral antibiotics, with no parenteral treatment authorized. (Parenteral refers to medicine being introduced into the body other than through the digestive tract, such as an injection into a vein or a muscle of the body). Additionally, if you are in a nursing home, then topical antibiotics may be used to improve your nursing home care.

Please <u>select one</u> of the following two options:

☐ **"<u>If there has been a Triggering Condition</u>**, I specifically direct that no attempts be made to treat any reversible secondary condition. In the event of infections, including pneumonia or other serious infections, I do not want parenteral antibiotics or oral antibiotics which in any way could be interpreted as life-saving or life-sustaining. **OR**

☐ "**<u>Even if there has been a Triggering Condition</u>,** I specifically desire that antibiotics continue to be used to treat any infection."

¥¥¥ ARTIFICIAL NUTRITION AND HYDRATION

If you are unable to eat by swallowing your food, artificial nutrition and hydration (i.e. provision of water) can be provided through intravenous means or a feeding tube. There are <u>three</u> options in this section.

☐ **Option #1: (Initiate/Continue Artificial Nutrition/Hydration)** **"**<u>Even if there has been a Triggering Condition</u>, I specifically desire that artificial means of nutrition and hydration be initiated and/or continued." **OR**

☐ **Option #2 (Discontinue Artificial Nutrition/Hydration)** <u>If there has been a Triggering Condition</u>, and <u>if two doctors determine that I would not experience severe or prolonged pain</u>**,** then I specifically do not want any artificial means of nutrition and hydration to be initiated and/or continued." **OR**

☐ **Option #3: (Discontinue Artificial Nutrition/Hydration)** <u>If there has been a Triggering Condition</u>, then I specifically do not want any artificial means of nutrition and hydration to be initiated and/or continued <u>even if the withholding of such treatment leads to my death, and even if it may involve me experiencing pain and suffering.</u>

<u>With Option 2 or 3, then the following language will appear</u>: "I wish for my mouth and lips to be kept moist so that the sensation of dehydration is relieved. It is my wish to die if nutrition cannot be provided in the normal manner. I understand that if artificial nutrition and hydration are withheld or withdrawn, I will probably die from dehydration within two weeks. I wish for all medical procedures used to provide me with nourishment and hydration (including, for example, parenteral feeding, intravenous feeding, and endotracheal or nasogastric tube use) to not be started, or to be discontinued if already started; and If I have designated a primary doctor, then one of the doctors making this determination should be my primary doctor designated if reasonably available."

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¥¥¥ BLOOD TRANSFUSIONS:

☐ **"**I grant my Health Care Agents the authority to authorize blood transfusions." **OR**

☐ **"**I refuse to grant my Health Care Agents the authority to authorize blood transfusions, for religious or other reasons."

¥¥¥ CHEMOTHERAPHY AND RADIATION THERAPY

Treatment for cancer can involve both radiation therapy and the use of drugs (i.e. chemotherapy) as treatment options. This section deals with your wishes regarding these forms of treatments.

***Note**: The default time noted for these option for "death is imminent" is within six (6) months or less. If you wish to have a shorter time period (i.e. fewer months) or a longer time period (i.e. more months), please indicate the number of months in the blank above. Select the options that you wish to appear in your Advance Health Care Directive:*

CHEMOTHERAPY OPTIONS

☐ Chemotherapy Specifically Authorized: "In the event that I am diagnosed with cancer and chemotherapy is proposed, I authorize and consent to chemotherapy even if such treatment is unlikely to improve my condition or to reduce pain." **OR**

☐ No Chemotherapy Authorized if Death if Imminent: "In the event that I am diagnosed with cancer and chemotherapy is proposed, I specifically direct that if death is imminent *within _____ months, my Agent shall not authorize or consent to chemotherapy if such treatment is unlikely to improve my condition or to reduce pain."

RADIATION THERAPY OPTIONS

☐ Radiation Therapy Specifically Authorized: "In the event that I am diagnosed with cancer and radiation therapy is proposed, I authorize and consent to radiation therapy even if such treatment is unlikely to improve my condition or to reduce pain." OR

☐ No Radiation Therapy if Death if Imminent: "In the event that I am diagnosed with cancer and radiation therapy is proposed, I specifically direct that if death is imminent *within _____ months, my Agent shall not authorize or consent to radiation therapy if such treatment is unlikely to improve my condition or to reduce pain."

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DESIRE FOR HOME CARE

(optional provision)

"If at all possible, and if doing so does not impose an undue cost or other burden on my family, I would like to live out my last days at home with appropriate medical, nursing, social, and emotional support and any necessary medical or other equipment needed to keep me comfortable.

My Health Care Agent may contact community or commercial social services organizations in order to facilitate my care at home, or, alternatively, my Health Care Agent may choose hospice care, or care in a facility that my Agent deems appropriate. However, if there has been a Triggering Condition, I refuse permission to be transferred to a hospital if the sole purpose is to prolong my life."

☐ **Include the Home Care provision**
☐ **Do <u>not</u> include the Home Care provision**

¥¥¥ ALZHEIMER'S OR OTHER DEMENTIA

(optional provision):

This section of your AHCD deals with whether or not you wish for certain life-sustaining treatments to be authorized or continued while others are specifically to be discontinued and not authorized. Read the following section.

"Regardless of anything I may say in my Advance Health Care Directive about withholding medical treatment or therapy, if I develop Alzheimer's disease or any other form of dementia, I would like all noninvasive life-prolonging treatments such as artificial nutrition, fluids, and antibiotics continued <u>as long as I have the ability to meaningfully interact with my family and friends, and am physically independent.</u> I would <u>not</u> want highly intrusive treatments such as CPR, mechanical ventilation, or kidney dialysis.

However, if I lose the capacity for meaningful interaction and physical independence, I then want only treatments that would make me more comfortable and free from pain, and I would <u>not</u> want artificial hydration or nutrition."

The determination whether I have the ability to meaningfully interact with my family and friends shall be made by two doctors. If I have designated a primary doctor, then one of the doctors should be such primary doctor if reasonably available."

☐ **Include the Alzheimer's provision**
☐ **Do <u>not</u> include the Alzheimer's provision**

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WAIVER OF MEDICAL CLAIMS
(optional provision)

NOTE: *This optional provision inserted into your Advance Health Care Directive can encourage a doctor, hospital, or other medical provider to act according to your wishes and follow the direction of your Agent without fear of being sued by upset family members and others who did not agree with your decisions, your medical treatment, or the withholding of such treatment. By shielding them from liability for acting (or not acting), they are more likely to follow your Advance Health Care Directive.*

"I hereby waive any claim my estate might have for wrongful death against any person who relies on any of my instructions in consideration for providing me with medical care consistent with my wishes as described in my Advance Health Care Directive. I further waive any claim I or my estate might have against any person who relies upon my Advance Health Care Directive for the authority of my Health Care Agent to consent to or to withdraw such medical care consistent with my wishes as described in my Advance Health Care Directive."

☐ **Include the Waiver provision**
☐ **Do <u>not</u> include the Waiver provision**

HOW LONG IS YOUR ADVANCE HEALTH CARE DIRECTIVE TO BE IN FORCE?

Your Advance Health Care Directive will remain in full force and effect until you decide to revoke it or replace it.

If you wish to limit it to a specific time period or wish for it to expire on a certain date, please write any expiration date or time period below:

_____

_____

_____

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AUTHORITY OF YOUR AGENT AFTER YOUR DEATH

AUTHORIZING AN AUTOPSY (please select one option)

☐ "I grant my Health Care Agent the power to authorize an autopsy."

☐ "I do not grant my Health Care Agent the power to authorize an autopsy, and, I wish for my Health Care Agent to resist any attempt to have an autopsy even if requested by police or medical authorities."

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ORGAN DONATION (please select one option)

☐ "I do not give permission to donate any of my organs"

OR

☐ "I authorize the donation of:

- ☐ Any of my organs, tissues or parts
- ☐ Only the following specific organs, tissues, or parts

My donated organs, tissues, or part may be used:

- ☐ for any purpose"
- ☐ only for the following purposes (select all that apply):"
  - ☐ Transplant ☐ Therapy
  - ☐ Research ☐ Education

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DISPOSITION OF REMAINS

The following instructions will be inserted into your Advance Health Care Directive:

"My Agent shall follow the directions of any writings that I have created concerning the disposition of my remains. If I have created more than one writing, the latest writing shall control;

If I have not left any writing, my Agent shall dispose of my remains based upon my Agent's knowledge of my wishes or any wishes communicated by me to my Agent; and

If my Agent does not have any knowledge of my wishes, nor were any wishes communicated to my Agent, my Agent shall respect the wishes of my family in determining how my remains will be disposed.

As of the date of execution of my Advance Health Care Directive, I have the following wishes concerning the disposition of my remains*: (Please insert any specific wishes concerning burial, memorial services, etc. If you run out of room, please continue in the "Other Wishes" section below, or on a separate sheet):*

_____

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_____

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<u>OTHER WISHES:</u> If you have any other wishes or desires that you want to have in your Advance Health Care Directive, please write them here:

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