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

MARTIN HEALTH SYSTEM

The Advance Directive and Living Will

Introduction to the Advance Directive and Living Will

Martin Health System's policy is that 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 Advance 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. Once you are a patient at Martin Health System and your advance directive is entered into your electronic medical record, it will remain there unless you make any changes.

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:

_____

_____ _____

Signature Date

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

I, _____, designate as my health care surrogate under s.765.202, Florida Statutes:
Name:_____ Phone: _____
Address: _____
_____
_____

If my health care surrogate is not willing, able, or reasonably available to perform his or her duties, I designate as my alternate health care surrogate:

Name: _____ Phone: _____
Address: _____
_____

Instructions for Health Care Surrogate

I authorize my health care surrogate to:
_____ (Initial) receive any of my health information, whether oral or recorded in any form or medium, that:

1. is created or received by a health care provider, health care facility, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
2. relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.

I further authorize my health care surrogate to:
_____ (Initial) make all health care decisions for me, which means he or she has the authority to:
1. provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
2. apply on my behalf for private, public, government, or veterans' benefits to defray the cost of health care.
3. access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
4. decide to make an anatomical gift pursuant to part V of chapter 765, Florida Statutes.

_____ (Initial) Specific instructions and restrictions:
_____

While I have decision making capacity, my wishes are controlling and my physicians and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation.
To the extent I am capable of understanding, my health care surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

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

Continued on other side

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

THIS HEALTH CARE SURROGATE DESIGNATION IS NOT AFFECTED BY MY SUBSEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA STATUTES.
PURSUANT TO SECTION 765.104, FLORIDA STATUTES, I UNDERSTAND THAT I MAY, AT ANY TIME WHILE I RETAIN MY CAPACITY, REVOKE OR AMEND THIS DESIGNATION BY:

(1) signing a written and dated instrument which expresses my intent to amend or revoke this designation;
(2) physically destroying this designation through my own action or by that of another person in my presence and under my direction;
(3) verbally expressing my intention to amend or revoke this designation; or
(4) signing a new designation that is materially different from this designation.

MY HEALTH CARE SURROGATE'S AUTHORITY BECOMES EFFECTIVE WHEN MY PRIMARY PHYSICIAN DETERMINES THAT I AM UNABLE TO MAKE MY OWN HEALTH CARE DECISIONS UNLESS I INITIAL EITHER OR BOTH OF THE FOLLOWING BOXES:

If I initial this box [_____], my health care surrogate's authority to *receive my health information* takes effect **immediately.**
If I initial this box [_____], my health care surrogate's authority to make health care decisions for me takes effect **immediately.** Per Florida law, any instructions or health care decisions I make, either verbally or in writing, while I possess capacity shall supersede any instructions or health care decisions made by my surrogate that are in material conflict with those made by me.
I specifically authorize and direct my healthcare providers to provide information about me to the following persons without asking my health care surrogate: _____

DESIGNATION OF SUPPORT PERSON

This individual may exercise visitation rights on my behalf when I am not able to do so. A support person may be a family member, friend, or other individual to support me during the course of my hospital stay.
The support person may or may not be my health care surrogate.
Designated Support Person _____

SIGNATURE OF PATIENT:

Date: _____ Signature: _____
Address: _____ Print Name: _____
City: _____ State: _____

SIGNATURES OF WITNESSES:

Print Name: _____ Print Name: _____
Address: _____ Address: _____
City: _____ City: _____
State: _____ State: _____

Signature: _____ Signature: _____
Date: _____ Date: _____