VERMONT ADVANCE DIRECTIVE FOR HEALTH CARE

YOUR NAME ______________________ DATE OF BIRTH __________ DATE ______________

ADDRESS ____

CITY ______________________ STATE __________ ZIP ______________

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 ____

(PART ONE CONTINUED NEXT PAGE)

NAME ______________________ DOB ______________ DATE ____________

Those who should *NOT* be consulted include:

I want my Advance Directive to start:

- ◯ When I cannot make my own decisions
- ◯ Now
- ◯ When this happens: ______________________

PART TWO: HEALTH CARE GOALS AND SPIRITUAL WISHES

My overall health care goals include:

- ◯ I want to have my life sustained as long as possible by any medical means.
- ◯ I want treatment to sustain my life only if I will:
  - ☐ be able to communicate with friends and family.
  - ☐ be able to care for myself.
  - ☐ live without incapacitating pain.
  - ☐ be conscious and aware of my surroundings.
- ◯ I only want treatment directed toward my comfort.

Additional Goals, Wishes, or Beliefs I wish to express include:

People to notify if I have a life-threatening illness:

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

- ◯ At home
- ◯ In the hospital
- ◯ Other: ______________________
- ◯ No preference

My Spiritual Care Wishes include:

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.

(PART THREE CONTINUED NEXT PAGE)

NAME ______________________ DOB ____________ DATE ____________

Additional Limitations of Treatment I wish to include:

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

My wishes for organ & 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 (please check & complete):

☐ 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 your 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:

____

(PART FOUR CONTINUED NEXT PAGE)

NAME ______________________ DOB ______________ DATE ____________

- ☐ 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)

Part Five: Signed Declaration of Wishes

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.

SIGNED ______________________ DATE ______________

I affirm that the signer 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)*

FIRST WITNESS (PRINT NAME)______________________

SIGNATURE ______________________ DATE ______________

ADDRESS ______________________

SECOND WITNESS (PRINT NAME)______________________

SIGNATURE ______________________ DATE ______________

ADDRESS ______________________

If the person signing this document is a current patient or resident in a hospital, nursing home or residential care home, an additional person (designated hospital explainer, long-term care ombudsman, member of the clergy, Vermont attorney, or person designated by the probate court) needs to confirm below that he or she has explained the nature and effect of the Advance Directive and that the patient or resident appears to understand this.

NAME ______________________ DATE ______________

TITLE / POSITION ______________________ PHONE ______________

ADDRESS ______________________

NAME ______________________________ DOB ______________ DATE ____________

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

- ☐ Vermont Advance Directive Registry Date registered______________________
- ☐ Health care agent
- ☐ Alternate health care agent
- ☐ Doctor/Provider(s): ______________________________
- ☐ Hospital(s): ______________________________
- ☐ Family Member(s): Please list:

NAME ______________________________

ADDRESS ______________________________

NAME ______________________________

ADDRESS ______________________________

NAME ______________________________

ADDRESS ______________________________

NAME ______________________________

ADDRESS ______________________________

NAME ______________________________

ADDRESS ______________________________

NAME ______________________________

ADDRESS ______________________________

What you should do with this Advance Directive

- ➢ Register your Estate Planning Documents for no fee at www.TheUSWillRegistry.Org
- ➢ It is suggested that you have your attorney review this form to be assured that it meets all your current state requirements.