ADVANCE CARE PLAN

This Advance Care Plan will help you tell your family and your doctors about the types of care you want if you become very ill. This document allows you to appoint a Health Care Agent, by filling in the APPOINTMENT OF HEALTH CARE AGENT block below. To be legally binding, this document must be either witnessed or notarized.

Part I. **APPOINTMENT OF HEALTH CARE AGENT**

(Durable Power of Attorney for Health Care)

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself. My Health Care Agent is my personal representative for all purposes under HIPAA. My Health Care Agent shall be obligated to make decisions based upon my best interests and as my Agent believes I would have acted if I had been able to decide for myself.

☐ If this block is checked, I want the appointment of my Health Care Agent to be effective immediately so that my Agent may assist me in connection with my health care.

Health Care Agent: I want the following person to make health care decisions for me:

Name: _____ Phone #: _____ Relation: _____

Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: _____ Phone #: _____ Relation: _____

Address: _____

Part II. **Advance Directive**

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. I know that some day I might suffer from a physical or mental condition that so severely harms my quality of life that I would not want to have any extraordinary means used to keep me alive. The examples below give guidance to my Agent, who has the authority to interpret them in acting to represent me. They are not intended to be exact requirements for treatment, since the circumstances of my final illness are likely to be different.

Initial Here if you agree with this Paragraph: _____ General Statement of Wishes: If I should ever suffer from a terminal condition and my treating physician has determined that there is no reasonable expectation that I can recover, and that continued medical treatment will only delay my death rather than cure me, I do not want my doctors to use extraordinary means to try to save me or keep me alive. Instead, I wish to be kept as comfortable and free from pain as possible and to be allowed to die naturally with only the medications and medical treatment my doctors deem necessary to make me comfortable and alleviate pain.

Treatment Options. I Do prefer the following treatment for my care if I am in the condition described above:
(You do not have to check any boxes if you prefer not to. You may leave this up to your Health Care Agent)

(1) CPR ☐ Yes ☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
(2) Life Support ☐ Yes ☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys or other organs to continue to work.
(3) Treat New Cond. ☐ Yes ☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness. (Pain symptoms should always be treated, whether curative treatment is indicated or not.)
(4) Tube Feeding ☐ Yes ☐ No	**Tube feeding/IV fluids:** Use of tubes (on a permanent basis) to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Hypothetical Questions: Quality Of Life Possibilities:

Review these questions and discuss your answers with your family to help them understand your feelings and how you would wish to be treated in these extreme situations. You do not have to answer all the questions, but any you do answer will help your Health Care Agent know how you would wish to be treated.

1. Permanent Confusion: I do not recognize loved ones or cannot communicate with them. I have become unable to remember, understand or make decisions. My life expectancy is uncertain.

If this happened, I prefer the following approach for my medical care.

(Select only ONE of the following. Make any additional notes to the side or on another page. You may indicate in the Treatment section below the types of treatment you wish to receive or do not want to receive for this illness.)

		COMMENTS:
A. I want to prolong my life, and to receive all medical care available to prolong my life.	☐ I Agree	_____
B. I do not want to receive medical care that only prolongs my life like this, except that I do want to receive artificial nutrition and hydration (tube feeding) if it would help me.	☐ I Agree	_____
C. I do not want to receive medical care that only prolongs my life like this. I do not want artificial nutrition and hydration. I do want medical treatment to make me comfortable and to alleviate pain.	☐ I Agree	_____

TREATMENT: (**Optional**—You may mark the treatments you do or don't want if you suffer from the conditions above. See Page 1 for explanation of the treatment options.) **(1) CPR: ☐ Yes ☐ No; (2) Life Support ☐ Yes ☐ No (3) Treat New Conditions ☐ Yes ☐ No.**

2. Permanent Unconscious Condition: I am totally unaware of people or surroundings and my doctors have determined there is no longer a significant likelihood of my ever waking up from the coma.

If this happened, I prefer the following approach for my medical care.

(Select only ONE of the following. Make any additional notes to the side or on another page. You may indicate in the Treatment section below the types of treatment you wish to receive or do not want to receive for this situation.)

		COMMENTS:
A. I want to prolong my life, and to receive all medical care available to prolong my life.	☐ I Agree	_____
B. I do not want to receive medical care that only prolongs my life like this, except that I do want to receive artificial nutrition and hydration (tube feeding) if it would help me.	☐ I Agree	_____
C. I do not want to receive medical care that only prolongs my life like this. I do not want artificial nutrition and hydration. I do want medical treatment to make me comfortable and to alleviate pain.	☐ I Agree	_____

TREATMENT: (**Optional**—You may mark the treatments you do or don't want if you suffer from the conditions above. See Page 1 for explanation of the treatment options.) **(1) CPR: ☐ Yes ☐ No; (2) Life Support ☐ Yes ☐ No (3) Treat New Conditions ☐ Yes ☐ No.**

3. End-Stage Illnesses: I have an illness that has reached its final stages in spite of all treatment and will result in my death. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or severely damaged heart or lungs, where oxygen is always required and my activities are severely limited due to the feeling of suffocation.

If this happened, I prefer the following approach for my medical care.

(Select only ONE of the following. Make any additional notes to the side or on another page. You may indicate in the Treatment section below the types of treatment you wish to receive or do not want to receive for this situation.)

COMMENTS:

A. I want to prolong my life, and to receive all medical care available to prolong my life. ☐ I Agree _____

B. I do not want to receive medical care that only prolongs my life like this, except that I do want to receive artificial nutrition and hydration (tube feeding) if it would help me. ☐ I Agree _____

C. I do not want to receive medical care that only prolongs my life like this. I do not want artificial nutrition and hydration. I do want medical treatment to make me comfortable and to alleviate pain. ☐ I Agree _____

TREATMENT: (**Optional**—You may mark the treatments you do or don't want if you suffer from the conditions above. See Page 1 for explanation of the treatment options.) **(1) CPR: ☐ Yes ☐ No; (2) Life Support ☐ Yes ☐ No (3) Treat New Conditions ☐ Yes ☐ No.**

4. Dependent in all Activities of Daily Living: I am no longer able to communicate or talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.

If this happened, I prefer the following approach for my medical care.

(Select only ONE of the following. Make any additional notes to the side or on another page. You may indicate in the Treatment section below the types of treatment you wish to receive or do not want to receive for this situation.)

COMMENTS:

D. I want to prolong my life, and to receive all medical care available to prolong my life. ☐ I Agree _____

E. I do not want to receive medical care that only prolongs my life like this, except that I do want to receive artificial nutrition and hydration (tube feeding) if it would help me. ☐ I Agree _____

F. I do not want to receive medical care that only prolongs my life like this. I do not want artificial nutrition and hydration. I do want medical treatment to make me comfortable and to alleviate pain. ☐ I Agree _____

TREATMENT: (**Optional**—You may mark the treatments you do or don't want if you suffer from the conditions above. See Page 1 for explanation of the treatment options.) **(1) CPR: ☐ Yes ☐ No; (2) Life Support ☐ Yes ☐ No (3) Treat New Conditions ☐ Yes ☐ No.**

Other instructions, such as burial arrangements, hospice care, etc.: _____

_____

_____

_____

(Attach additional pages if necessary)

_____

Organ Donation (optional):

Upon my death, I wish to make the following anatomical gift (please mark one if you wish to donate):

☐ **I DESIRE TO DONATE** any of my organs and/or tissues needed for transplantation.

☐ **I DESIRE TO DONATE only the following** organs/tissues: _____

☐ **I DO NOT DESIRE TO DONATE**

☐ **I want to donate my entire body**

_____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized.

If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Your (Principal's) Signature: _____ Date: _____

Your ("Principal's") Printed Name: _____

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "Principal." The Principal personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the Principal appears to be of sound mind and under no duress, fraud, or undue influence.

Date: _____

_____
Signature of Notary Public

SEAL
My commission expires: _____

_____

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Tell your closest relatives and friends about it
- Keep a copy where it is accessible to others
- Provide a copy to your Health Care Agent