PROXIMITI HEALTH

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Vermont Advance Directive

My Name _____.Date of Birth (DOB)_____Date_____

Address _____

_____

City State zip

Part One: Appointment of My Health Care Agent

I appoint _____

Address _____

Phone (day)_____ . (Evening) _____

Cell phone _____.email _____

as my health care **agent** to make any and all health care decisions for me, *except to the extent that I state otherwise in this document.* (If you appoint co-agents, list above or on a separate sheet of paper.)

If this health care agent is unavailable, unwilling, or unable to do this for me, I appoint _____.to be my **alternate agent.**

Address _____

Phone (day)_____ . (Evening) _____

Cell phone _____.email _____

(Use additional sheet to appoint additional agents or alternates.)

Others who can be consulted about medical decisions on my behalf include:

_____

_____

Those who should *NOT* be consulted include:

_____

_____

Your agents should have been notified that you appointed them. They should understand your wishes and they should agree to make health care decisions for you when you are no longer able to, or no longer wish to make them for yourself.

(Optional space below is to identify your doctor or health care provider:)

Primary care physician(or other health care clinician)_____

Address _____phone _____

Other health care professional _____

Address _____phone _____

Part Two: Treatment Wishes

Please initial the statements below that fit your preference. You may initial more than one choice. *If you choose nothing, your agent, family members, and doctors will assume you want them to decide for you. If you do not state a preference for withholding or withdrawing tube feeding, and you are being treated in a hospital in another state, your agent may not have authority to withhold or withdraw it, without a court order.*

The statements below are applicable at a time when I may be so ill, injured or impaired that I lack the capacity to make my own medical decisions

_____ **A. My choice is to try to Sustain Life.** I want my life to be prolonged as long as possible through any reasonable medical means regardless of my condition or awareness or quality of life. (If this statement sums up your wishes, you may wish to move on to the signature section of Part Five.)

_____ **B. I do not want my life prolonged if** (initial all that apply):

_____ I am so sick that I have only weeks, days, or hours left to live.

_____ I become unconscious or unaware of my surroundings and my doctors agree that I will never regain consciousness.

_____ I become unable to think or act for myself and won't get better.

_____ If it becomes clear to my doctor, my agent, and those caring for me that I am dying, I want comfort care to relieve my pain and other symptoms that are bothering me. I want sufficient **pain medication** even though it may have the unintended effect of hastening my death.

_____ I prefer to die at home if possible and be referred to **Hospice care**.

_____ **C. My Choice is to Limit Treatment in the following ways, even if none of the conditions I've checked in Part B apply:**

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-pulmonary resuscitation, including vigorous compressions of the chest and air forced into the lungs through a facemask.

2. If I am unable to breathe on my own: (choose one)

_____I **DO** want a breathing machine without any time limit to keep me alive.

_____I want a breathing machine for a short time to see if I will survive or get better.

_____I **DON'T** want a breathing machine.

"Breathing machine" refers to a ventilator or respirator, not to portable machines that may support my breathing with oxygen.

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 limit.

_____I want to have a feeding tube for a short time to see if I will survive or get better.

_____I **DON'T** want a feeding tube for any length of time.

_____I want my health care agent to decide about feeding tubes.

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.

_____ **D. Other specific instructions or comments are as follows:**_____

_____

_____

_____

Spiritual and Other Care Concerns

I am of the _____ faith. Below is the contact information (if known).

Church, synagogue, or worship center:_____

Address _____

_____

Leader _____ Phone _____

Other people to notify if I have a life-threatening illness: _____

_____

_____

_____

The following items or music or readings would be a comfort to me: _____

_____

_____

Part Three: Instructions about Organ and Tissue Donation

I wish to make known my decisions regarding organ and tissue donation and whole body donation so that my instructions will be followed after my death.

I **consent to donate** the following organs and tissues:

____ any needed organs (heart, lung, kidney, liver)

____ any needed tissue (such as cornea, bone, and skin)

I do **not** wish to donate the following organs and tissues:

_____

_____

____ I wish to make **no decision** about organ and tissue donation at this time.

____ I do **not** wish to be an organ and tissue donor.

____ I wish to donate my body to research or educational programs. (Note: you will have to make your own arrangements through a medical school or other program in advance.)

____ If an **autopsy** is suggested for any reason, I consent to have it done

Part Four: My Wishes for Disposition of My Remains After My Death

I. I have a **pre-need contract** for funeral arrangements with the following funeral service:
Name _____

Address _____

Phone _____

II. My preference for **those who should decide** about my burial or disposition of my remains after I die—I want the following person or persons to decide arrangements after my death:

❑ health care agent ❑ alternate agent ❑ family ❑ Other designee (specify below):

Name _____.

Address _____

Phone_____ .Cell phone_____

email _____

III. Specific Wishes:

____ I want a funeral followed by burial in a casket.

____ I want to be cremated and my ashes kept or scattered as follows:

_____

_____

_____

____ If it is possible, I would like my remains to be buried at the following location (name of cemetery, city, state, etc.):

_____

_____

_____

Part Five: Signed Declaration of Wishes

I declare that this document reflects my desires regarding my future health care (organ and tissue donation and disposition of my body after death) and that I am signing this Advance Directive of my own free will.

Signed _____.Date _____.

The witnesses below confirm the signature of the maker of this document and that it is being signed by that person as a free and voluntary act. Witnesses affirm that Principal appears to understand the nature of the Advance Directive and there is no duress or undue influence to sign. *The following people may **not** sign as witnesses: your agent(s), spouse, reciprocal beneficiary, parents, siblings, children, or grandchildren.*

(Please sign and print)
First Witness _____ Date_____

Address _____

First Witness _____ Date_____

Address _____

If the maker 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 the patient or resident appears to understand this.

First Witness _____ Title/Position_____

Address _____

Date _____

Important!

Please check below the people and locations that will have a copy of this document:

❑ Vermont Advance Directive Registry— Date registered: _____

❑ Health care agent ❑ Alternate health care agent

❑ Family members *(List all who have copies)*:

Name _____.

Address _____

Name _____.

Address _____

Name _____.

Address _____

Name _____.

Address _____

❑ MD Name_____

Address _____

❑ Hospital(s) _____

_____

_____

DISCLAIMER: The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.