Introduction to the Advance Directive Living Will

Every competent adult may someday be called upon to make the decision to accept or refuse medical treatment. When you are well, you can talk with your physician and family and make your wishes known. However, severe illness or 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 written instructions from you, your family and physicians would have to guess what treatment you would want. In some cases, they may be forced to proceed with treatments they know you would not desire simply because your preference was not expressed in writing. You can help your family and physicians by telling them, in advance, what you would want done in certain situations. This planning ahead is called "ADVANCE DIRECTIVE." Your ADVANCE 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.

You may 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 obliged to make the choices he or she believes you would make if you were able. Your DIRECTIVE can assist your surrogate in determining what your wishes would be.

Before you fill out the ADVANCE DIRECTIVE - LIVING WILL form, you may want to talk to your family, friends, physician, lawyer, or spiritual advisor. If you choose to designate a HEALTH CARE SURROGATE, since that person may some day be called upon to make decisions on your behalf, you may want to discuss your thoughts with your surrogate.

When you make your personal choices in the DIRECTIVE, you may want to consider one question. Is there a condition or set of circumstances which could exist in which you would refuse efforts to prolong your life? The DIRECTIVE in this brochure 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.

After you complete it, give a copy to your regular physician, your health care surrogate and to a trusted family member or friend.

THE ADVANCE DIRECTIVE - LIVING WILL FORM IS A COMMUNITY SERVICE PROJECT OF TALLAHASSEE MEMORIAL HOSPITAL. IF YOU HAVE ANY QUESTIONS ABOUT THE DIRECTIVE, CONTACT YOUR ATTORNEY, PHYSICIAN OR CLERGYMAN. Additional copies of the form may be obtained through Tallahassee Memorial Hospital. Brochure copy courtesy Lakeland Regional Medical Center.

Instructions for completion:

If you were in the condition described in the three situations, what would your choice be regarding the possible treatment listed to the left? Make your choice by placing your initials in the appropriate box.

Note:

In many cases in the situations described below, it may take days or even weeks for the prognosis 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 your physician and at least two consultants share the opinion regarding the outlook for your recovery. The possible treatments are considered only if medically reasonable.

Possible Treatments:	Situation A	Situation B	Situation C
Assume none of the following will improve or cure the condition described in these situations:	If I am in a coma, or in what is called a persistent vegetative state, and have no 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:	If I have a progressive illness, which will continue to worsen and result in my death and which cannot be improved or cured, when 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:	If I have a condition which makes me unable to recognize people or speak understandably, and that condition is permanent and cannot be improved or cured but is NOT terminal, my wishes regarding the following would be:
1. Do you want efforts to be made to resuscitate (chest massage, artificial breathing) you if your heart or breathing stops?	_____ 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 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) even if it cannot improve or cure your condition?	_____ YES _____ NO _____ UNDECIDED	_____ YES _____ NO _____ UNDECIDED	_____ YES _____ NO _____ UNDECIDED
4. Do you want any surgery, even if it is lifesaving, if it cannot improve or cure your condition?	_____ 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

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 / Instructions:

_____

_____

_____

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Appointment of a Health Care Surrogate:

Now that you have made your wishes known, you may choose a person to make medical decisions which may not have been specifically addressed by your ADVANCE DIRECTIVE - LIVING WILL. This person is called your HEALTH CARE SURROGATE and if you are unable to make your own decisions, he/she shall have the authority to:

(a) Act for you to make health care decisions which he/she believes you would have made under the circumstances if you were able;

(b) Consult with appropriate health care providers to provide informed consent in your best interest and give consent in writing on the appropriate forms;

(c) Have access to your clinical records and authority to release information and clinical records to appropriate persons to provide continuity of care;

(d) Apply for public benefits (such as Medicare and Medicaid) for you and have access to information about your income and assets as needed to make the application; and

(e) Authorize the transfer and/or admission of you to or from a health care facility.

I hereby execute this ADVANCE DIRECTIVE - LIVING WILL and appoint _____ (enter "none" if Surrogate is not being appointed) as my Health Care Surrogate and authorize him/her to make all decisions for me which he/she believes I would have made.

As to decisions regarding the withholding or withdrawing of life-prolonging procedures (including artificial nutrition and hydration):

_____ I DO AUTHORIZE my surrogate to make such decisions.
_____ I DO NOT AUTHORIZE my surrogate to make such decisions.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

_____ _____ _____
(Date) (Declarant's Signature) (Date of Birth)

_____
(Declarant Print Name)

The declarant is known to me, and I believe him or her to be of sound mind.

_____ _____
(Date) (Witness — any adult)

_____
(Witness — cannot be spouse, blood relative, heir or person responsible for health care costs)

I hereby accept the above designation as Health Care Surrogate:

1300 Miccosukee Road
Tallahassee, Florida 32308
www.tmh.org

Tallahassee Memorial HealthCare

Lawson # 17353 FORM # 222999 (03/08) FMI

The Advance Directive Living Will of

_____

_____

Tallahassee Memorial HealthCare