ADVANCE DIRECTIVE

My Name: _____ **Date of Birth:**_____

Address: _____

Part One: Appointment of My Health Care Agent

I appoint _____ Address: _____
Tel. #s: (days) (518)_____ (eves.)_____ Cell: (518)_____
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 this health care agent is unavailable, unwilling or unable to do this for me, I appoint _____ to be my **Alternate Agent.**

Address: _____
Tel. #s: _____ Cell: _____ 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 can no longer make them for yourself.

(Optional space below is to identify your doctor or health care provider:) *Your doctor cannot also serve as your health care agent.

Primary care physician _____ Address: _____
(or other health care professional) Office Telephone: _____

Part Two: Treatment Wishes

Please express your preferences that follow by checking or initialing the statements. **You may check or initial more than one choice.** If you do nothing, your agent or others such as family members and doctors treating you will assume you want them to decide for you. If you do not state a preference for withholding or withdrawing artificial food (tube feeding) and hydration, your agent may not have authority to withhold or withdraw it, without a court order.

_____ **A. <u>My Choice is to Limit Treatment</u>** - I do not want to be kept alive if:
(Initial those statements below that you agree with)

____ 1. I am so sick that I will die within a relatively short time (I cannot get better and have only weeks, days or hours left to live),
____ 2. I become unconscious or unaware of my surroundings and most doctors agree that I will never regain consciousness,
____ 3. I become unable to think or act for myself (and won't get better), or
____ 4. The likely risks and burdens of treatment would outweigh the expected benefits. (For example: I will be in pain, or I will be unable to do things for myself, or the costs of caring for me will be beyond my willingness to pay.)
____ 5. If it is possible that I might recover with treatment and **more time is needed** to determine if I can get better or not, I wish my medical team to start the necessary treatments to keep me alive. If, over time, these treatments do not improve my chances of living or my physical condition, I wish to have life-sustaining treatment stopped.
____ 6. If I am unable to swallow enough food and water to stay alive, I **do** want food and water to be given to me by vein or by feeding tube; **or,**
____ 7. If I am unable to swallow enough food and water to stay alive, I **do <u>not</u>** want food and water to be given to me by vein or feeding tube, but I will accept medication for pain and agitation through an intravenous line.
____ 8. Other specific instructions are as follows:

_____

_____

____ **B. <u>My Choice is to Sustain Life</u>** - I want to be kept alive as long as possible through any means possible regardless of my condition or awareness.

Specific Care Wishes Near the End of My Life

____ If it becomes clear to my doctor, my agent and those caring for me that I am dying, I want palliative care for my pain, worries, nausea and other conditions that bother me. I want sufficient pain medication even though it may have the unintended effect of hastening my death.

____ I want hospice care when I am dying, if possible and appropriate.

____ I prefer to die at home, if this is possible.

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: Specific Instructions about ORGAN DONATION

I want my agent (if I have appointed one), family, friends and all who care about me to follow my wishes about organ donation if that is an option at the time of my death. (Initial below all that apply.)

_____I wish to donate the following organs and tissues:
____ any needed organs or tissues
____ major organs (heart, lungs, kidneys, etc.)
____ tissues such as skin and bones
____ eye tissue such as corneas
_____ I do not wish to be an organ donor.
_____ I desire 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.)

Part Four: My Wishes for Disposition of my Remains after my Death:

_____ If an **autopsy** is suggested for any reason, I give my permission to have it done.

The person I want to serve as my agent for disposition of my body:
a) ____ I want my health care agent to decide arrangements after my death.
____ If he or she is not available, I want my alternate agent to decide.

b)____ Regardless of my appointment of a health care agent in Part One, I appoint the following person to decide about and arrange for the disposition of my body after my death:

Name _____ Address _____

Telephone _____ Cell phone _____ Email _____

OR

c) ___ I want my family to decide.

My preference for Burial or Disposition of My Remains after Death:

a)____ I want a funeral followed by burial in a casket at the <u>following location, if possible</u> (please tell us where the burial plot is located and whether it has been pre-purchased): Calvary Cemetery, 2407 Oneida Street, Utica, NY (not pre-purchased).

b)____ I want to be cremated and have my ashes buried or distributed as follows:

c)____ I want to have arrangements made at the direction of my agent or family.

I have a pre-need contract for funeral arrangements with the following Funeral Service:

Name _____ Address _____

_____ Tel. _____

Part Five: ***Signed Declaration of Wishes***

Signed _____ Date: _____

The witnesses below confirm the signature of the maker of this document and that it is a free and voluntary act. The following people may <u>not</u> be witnesses: your health care agents, your spouse or partner, reciprocal beneficiary, adult siblings, parents, adult children and grandchildren.

(sign and print)

Witness _____ Date _____

Address _____

Witness _____ Date _____

Address _____

If the maker is a current patient or resident in a hospital, nursing home or residential care home, the following additional witness confirms the maker's capacity, understanding, and freedom from undue influence (Hospital Explainer or Long-term-care Ombudsman or clergy, attorney, or probate court designee):

Name _____ Address _____

Title/position _____ Date _____

Important!

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

____ Health care agent

____ Alternate health care agent

_____ Family members: (List by name all who have copies)

Name _____ Address_____

_____ _____

_____ _____

_____ MD (Name)_____Address_____

_____ Hospital (s) (Names)_____

_____ Other individuals or locations: (list by name on added pages):