UMMC ADVANCE HEALTHCARE DIRECTIVE

EXPLANATION

This form is valid in any healthcare setting.
Under federal and Mississippi law, you have the right to make health care decisions for yourself**.** If you are too sick to make your own decisions or if you just want someone else to make your medical decisions you can name a person who can make these decisions for you. This person is called your Health Care Agent.

IMPORTANT FACTS

*The form used to document this decision is called an Advance Healthcare Directive: This form has 2 parts:
Part 1. Name your Health Care Agent.
Part 2. State your wishes

*Your primary doctor or any of your treating doctors will make the decision whether you are too sick to make your own decisions.

*You should choose a trusted family member or friend who will be available and knows your wishes. You can list 2 people in order. If you are in a nursing home, you cannot choose someone who works there unless the person is related to you.

*According to the law, if you do not have a health care decision maker, your doctor will ask your family members to make decisions **in this order: 1. Spouse, 2. Adult children, 3. Parents, 4. Adult brothers and sisters, 5. Others who know you well**.

*Writing your wishes down and discussing these wishes with family and friends is important. It is the only way they can honor your requests.

After you complete this form, keep it in a safe place and share it with your family and friends. A copy of the form is the same as an original so make sure a copy is easily accessible if needed.

* To make this document legal you can either sign & date this form in front of two witnesses or in front of a notary public. You DO NOT need both.

Remember, you can always change your mind.
You have the right to revoke this advance health care directive or replace this form at any time.

BEFORE YOU COMPLETE PART 2 YOU WILL NEED TO CONSIDER THE FOLLOWING THREE ISSUES

1. DECISIONS MY HEATH CARE AGENT CAN MAKE FOR ME IF I CANNOT DECIDE OR I AM NOT ABLE TO SPEAK FOR MYSELF

- **A.** Choose my health care providers
- **B.** Make all health care decisions for me. This includes the power to agree to, refuse, change or stop any care, treatment, service or procedure.
- **C.** Choose where I live and get health care, including the authority to admit me to a nursing home or community-based residential facility.
- **D.** Review my medical records and give them to other people as needed for my medical care.

2. DECISIONS ABOUT LIFE SUPPORT

There are several life support treatments that may be used to try to help you live longer. These include:

A. A breathing machine—temporary or permanent

B. Artificial feeding or fluids through tubes—temporary or permanent

C. Attempts to start a stopped heart (CPR)—shock treatments, chest compressions, medications and placed on a breathing machine
D. Surgeries
E. Kidney dialysis—temporary or permanent
F. Antibiotics and blood transfusions.

Most of these treatments can be tried for a period of time and then stopped if they do not help. In the Advance Healthcare Directive form, you can state your wishes on these treatments.

3. DECISIONS ABOUT QUALITY OF LIFE

It is important that your Health Care Agent understands your thoughts and feelings about quality of life. What if?
-You cannot think clearly; you cannot feed, bathe or take care of yourself; you cannot walk; you cannot control your bladder or bowels; you have severe pain or other severe symptoms that are difficult to control; you cannot interact with others due to unconsciousness or you do not know family/friends due to brain dysfunction.

What do you consider to be a minimum of function for you to have quality of life?

OR

Do you feel that your life is worth living no matter how sick you are?

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PART 1
ADVANCE HEALTH CARE DIRECTIVE

I, _____, am using this form to appoint a health care agent to make health care decisions for me if I cannot decide or speak for myself.

MY HEALTH CARE AGENT (see explanation page 1)

When I am not able to decide or speak for myself, I appoint the following person as my health care agent or alternate agent to make health care decisions for me.

*I want my agent to use what I say in this document or wishes I have made known to my agent as a general guide when making decisions about my care.
*If I have not given health care instructions, I want my agent to act in my best interest.

My health care agent can make these decisions (initial one)
If I am too sick to make these decisions_____
The date this form is signed_____

My primary health care agent

Name: _____Relationship to me: _____

Address: _____
Phone numbers: _____
(Home) (Work) (Mobile)

My alternate health care agent if I have chosen one
Name: _____Relationship to me: _____
Address: _____
Phone numbers: _____
(Home) (Work) (Mobile)

My agent is authorized to make all health care decisions for me except as I state here: _____
_____
_____

Nomination of Guardian: If a guardian needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as guardian, I nominate the alternate agent whom I have named, in the order designated.

PART 2: STATING MY WISHES

(OPTIONAL)

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you do not need to fill out this part of the form. If you do fill out this part of the form, you may strike out anything you do not want.

END OF LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

_____A. Choice Not to Prolong Life

I do not want my life to be prolonged if
(1) I have an incurable and irreversible condition that will result in my death within a relatively short time
(2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness
(3) The likely risks and burdens of treatment would outweigh the expected benefits, or

_____B. Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

I understand, based on the above choice that artificial nutrition (feeding tubes) and hydration (IV fluids) may be provided in accordance with my choice unless I state otherwise below.

ARTIFICIAL FEEDING AND HYDRATION

_____

_____

PAIN RELIEF_____

ORGAN DONATION: (initial one)

YES_____
NO_____
MY AGENT'S DECISION_____

OTHER WISHES

_____

_____

You may choose to sign and date this form in front of two witnesses or in front of a notary public. (Option 1 or 2)

I am thinking clearly. I agree with everything that is written in this document. I have made this document willingly.

My signature: _____

Date signed: _____

My birth date: _____

My address: _____

MAKING THE FORM LEGAL
OPTION 1
Use this form if you sign in front of two witnesses
Witness 1

I declare under penalty of perjury that the principal is personally known to me, that the principal signed this document in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility. I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

_____

Date **signature of witness**

_____

Address **printed name of witness**

_____

City & state

Witness 2

I declare under penalty of perjury that the principal is personally known to me, that the principal signed this document in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence, that I am not the person appointed as agent by this document, and that I am not a health care provider, nor an employee of a health care provider or facility.

_____

Date **signature of witness**

_____

Address **printed name of witness**

_____

City & State

OPTION 2

Use this form if you sign in front of a notary public.

State of _____

County of _____

On this _____day of _____in the year_____, before me_____

Appeared _____, personally known to me (or provided to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under the penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

NOTARY SEAL

_____

Signature of notary public