HOW TO COMPLETE YOUR ADVANCE HEALTHCARE DIRECTIVE

This form lets you write down your wishes in case you get very sick and cannot make your own decisions. It has three parts: (1) choosing a healthcare decision maker; (2) writing out your healthcare choices; and (3) signing/validating the form. Below are instructions for completing those parts. The actual form begins on page 3.

PART 1 INSTRUCTIONS: CHOOSE A HEALTHCARE DECISION MAKER.

A healthcare decision maker is someone who can make healthcare decisions for you if you are too sick to make them yourself. You should also name a backup decision maker, since your first choice might not always be willing or able to speak for you when the time comes.

WHOM SHOULD YOU CHOOSE?

A trusted family member or friend who knows you well and can be available if you get very sick. You cannot choose someone who works at a nursing home or similar facility where you are being treated unless you are related to him or her.

WHAT WILL HAPPEN IF YOU DO NOT CHOOSE A HEALTHCARE DECISION MAKER?

If you are too sick to make your own decisions, your doctors will turn to your family to make decisions for you in the following order: (a) spouse; (b) adult children; (c) parents; (d) adult brothers and sisters; and (e) others who care about you and might know what is important to you.

WHAT KINDS OF DECISIONS CAN YOUR HEALTHCARE DECISION MAKER MAKE?

He or she can make any healthcare decision for you but **must** follow the wishes you describe in Part 2.

WHEN WILL MY HEALTHCARE DECISION MAKER BE ABLE TO MAKE DECISIONS FOR ME?

You have a choice: (a) only when you cannot make your own decisions; or (b) right after you sign the form. If you choose option (a), someone must decide when you are not able to make your own decisions. That person will be either your primary doctor or any of your treating doctors (if you are in a hospital).

PART 2 INSTRUCTIONS: WRITE DOWN YOUR HEALTHCARE CHOICES.

Write down your healthcare choices so that your healthcare decision maker will not have to guess what you want if you are too sick to tell him or her yourself.

WHAT ARE LIFE SUPPORT TREATMENTS?

Life support treatments are medical care that might be used to **try** to help you live longer. They might include the following:

Breathing Machines. Machines that pump air into your lungs and breathe for you.

Blood Transfusions. Putting blood into your veins, usually to replace blood loss.

Dialysis. Machines that clean your blood if your kidneys are not working well.

IV Drugs. Medicines given by injecting them directly into your veins.

CPR. This may involve pressing hard on your chest to keep your blood pumping, electrical shocks to jump start your heart, or medicines in your veins.

Feeding Tube. A tube used to feed you if you cannot swallow. The tube might be placed down your throat into your stomach, **or** it might be placed into your stomach by an operation.

WHAT IS HOSPICE CARE?

Hospice care is end-of-life care. It is a special form of care for people at the end of life when all attempts at cure have been stopped. Hospice patients typically do not receive treatments intended to prolong life, and the hospice care team will focus on keeping the patient comfortable.

WHAT IF I CHANGE MY MIND?

That is fine. Your choice is important. The best thing to do is complete a new form, tell your caregivers about your changes, and give the new form to your healthcare decision maker and doctor.

PART 3 INSTRUCTIONS: SIGNING THE FORM

No matter what, you must sign and date the form, and it must be either (a) notarized, **or** (b) signed by two witnesses. It does not matter which option you choose. You do not need both. Whatever you choose, he/she/they need to watch you sign the form.

CAN ANYONE BE A WITNESS OR NOTARY?

No. None of the following people can be witnesses or notarize the form: (a) a health-care provider (like a doctor or nurse); (b) an employee of a health-care provider or facility; (c) your healthcare decision maker. Also, at least one witness must be someone unrelated to you who would not get any of your money or property when you die.

ADVANCE HEALTHCARE DIRECTIVE OF

_____

(print your name here)

PART 1: CHOOSE A HEALTHCARE DECISION MAKER

1.1. **Healthcare Decision Maker**. I choose the following person as my healthcare decision maker:

First Name	Last Name		Relationship
Home Number	Work Number		Cell Number
Street Address	City	State	Zip Code

If I take away that person's authority or if that person is not willing, able, or available to make a healthcare decision for me, I choose the following person as my alternate healthcare decision maker:

First Name	Last Name		Relationship
Home Number	Work Number		Cell Number
Street Address	City	State	Zip Code

1.2. **Healthcare Decision Maker's Authority**. My healthcare decision maker must make all healthcare decisions according to my wishes described in Part 2. If my medical treatment choices are not clear, he or she must make those decisions in my best interest and based on what is known of my wishes.

1.3. **Effective Date.** My healthcare decision maker can make healthcare decisions for me:

(CHOOSE ONE)

☐ only if I cannot make my own decisions. Either my primary doctor named in section 1.4 or any of my treating doctors (if I am in a hospital) can decide whether I am able to make my own decisions.

☐ right after I sign this form.

1.4. **Primary Doctor**. My primary doctor is (if I have one):

First Name	Last Name		Phone Number
Street Address	City	State	Zip Code

PART 2: WRITE DOWN YOUR HEALTHCARE CHOICES.

2.1. **My Life Values**. My life is not worth living to me if I cannot:

(CHECK ALL THAT APPLY)

☐ talk to family or friends.

☐ feed, bathe, or take care of myself.

☐ be free from pain.

☐ live without being hooked up to machines.

☐ Other (use additional sheets if needed):_____

_____

_____

☐ None of the above. My life is always worth living no matter how sick I am.

2.2. **Religion**. What, if anything, should your healthcare decision maker and doctors know about your religious or spiritual beliefs (use additional sheets if needed)?

_____

_____

_____

2.3. **End of Life**. If I am so sick that I might die soon:

☐ Try all life support treatments that my doctors think might help. *If the treatments do not work and there is little hope of getting better, I:*

__ *want to stay on life support machines even if I look like I am suffering.*

__ *want to stay on life support machines unless it looks like I am suffering.*

__ *do not want to stay on life support machines even if I do not look like I am suffering.*

☐ I do not want life support treatments, and I want to focus on being comfortable. I prefer to have a natural death.

☐ I want my healthcare decision maker to decide for me.

☐ Other (use additional sheets if needed):_____

_____

_____

2.4. **Final Days**. I want to spend my final days:

(CHOOSE ONE)

☐ at home.

☐ at home, and I would like to receive hospice care at home if possible.

☐ in a facility that provides hospice care.

☐ Other (use additional sheets if needed):_____

_____

Do you agree with the following statement: Ultimately, I want to spend my final days in the place that is most convenient for my family even if that place is different from what I chose above.
☐ AGREE ☐ DISAGREE

2.5. **Pain Relief**. I want to receive treatment for pain relief at all times, even if it quickens my death. ☐ AGREE ☐ DISAGREE

2.6. **Mental Health**. My healthcare decision maker is allowed to admit me to a mental healthcare institution. ☐ AGREE ☐ DISAGREE

2.7. **HIPAA**. My healthcare decision maker is my personal representative for purposes of the Health Insurance Portability and Accountability Act and can therefore get information about my protected health information, talk to my doctors, etc.

2.8. **Consent to Donate**. My wishes regarding giving my body parts after I die are described below:

(CHOOSE ONE)

☐ I want to give away as many of my organs, eyes, and tissues as possible for the purpose of transplantation, therapy, research, or education.

☐ I only want to give away the following organs, eyes, and/or tissues for the purpose of transplantation, therapy, research, or education:_____

_____

_____

☐ I do not want to give away my organs, eyes, or tissues for the purpose of transplantation, therapy, research, or education.

☐ Other (use additional sheets if needed):_____

_____

Complete this sentence if it is true: I am already a body donor and have filled out the required consent forms with the following facility:_____

PART 3: SIGN AND DATE THE FORM

DO NOT SIGN THIS FORM UNLESS A NOTARY OR TWO WITNESSES ARE WATCHING YOU.

The notary or witnesses will validate your signature on the next page.

You need a notary **or** two witnesses, but not both.

I am signing this Advance Healthcare Directive, on _____, 20___.

Signature:_____

Print Name:_____

Date of Birth:_____

OPTION A: NOTARY

STATE OF _____

COUNTY OF _____

On this ____day of_____, 20___, before me appeared _____ personally known to me (or proved 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 PUBLIC

My Commission Expires:

_____

OPTION B: TWO WITNESSES

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney 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.

Signature: _____

Print Name: _____

Date: _____

Address: _____

I declare under penalty of perjury pursuant to Section 97-9-61, Mississippi Code of 1972, that the principal is personally known to me, that the principal signed or acknowledged this power of attorney 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.

Signature: _____

Print Name: _____

Date: _____

Address: _____