INSTRUCTIONS

Part One. Designation of Health Care Surrogate

PRINT YOUR NAME

Name: ____
(Last) (First) (Middle Initial)

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR SURROGATE

Name: ____

Address:____

_______________________________________ Zip Code: ____________

Phone: ____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

PRINT THE NAME, HOME ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE SURROGATE

Name: ____

Address:____

_________________________________ Zip Code: ____________

Phone: ____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

When making health care decisions for me, my health care surrogate should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in Part Two (if I have filled out Part Two), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care surrogate should make decisions for me that my health care surrogate believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

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ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

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Additional instructions (optional):

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INSTRUCTIONS

PRINT THE DATE

PRINT YOUR NAME

INITIAL EACH THAT APPLIES

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Part Two. Declaration

Declaration made this __________ day of ___________________, _________,
(day) (month) (year)

I, ____,
willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that:

If at any time I am incapacitated and

(initial all that apply)

_______ I have a terminal condition, or

_______ I have an end-stage condition, or

_______ I am in a persistent vegetative state

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

My failure to designate a health care surrogate in Part One shall not invalidate this declaration.

ORGAN DONATION (OPTIONAL)

INITIAL ONLY ONE OF THE FOUR OPTIONS

ORGAN DONATION (OPTIONAL)

I hereby make this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give (initial one choice below):

______ any needed organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education;

______ only the following organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education:

____
____
____

______ my body for anatomical study if needed. Limitations or special wishes, if any:

____
____
____

IF YOU HAVE ALREADY ARRANGED TO DONATE YOUR ORGANS TO A SPECIFIC DONEE, INITIAL THIS OPTION, AND INDICATE THE DETAILS OF YOUR ARRANGEMENT HERE

______ I have already arranged to donate
______ Any needed organs, tissues, or eyes,
______ The following organs, tissues, or eyes:

____
____
____

to the following donee:___________________________________

Phone:____

Address:____

____________________________________ Zip Code:__________

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PRINT YOUR NAME

SIGN AND DATE THE DOCUMENT

TWO WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

OPTIONAL

PRINT THE NAMES AND ADDRESSES OF THOSE WHO YOU WANT TO KEEP COPIES OF THIS DOCUMENT

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Part Three. Execution

I, ____
understand the full impact of this declaration, and I am emotionally and mentally competent to make this declaration. I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility.

Signed: ____

Date: ____

Witness 1:

Signed: ____

Address: ____
____

Witness 2:

Signed: ____

Address: ____

____

(Optional) I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is:

Name: ____

Address:
____
____

Name: ____

Address: ____

____

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898