ADVANCED DIRECTIVES FAQS

LABRADOR PRIMARY CARE CENTER

What is an advanced directive?

It is a written or oral statement about how you want medical decisions made should you not be able to. Some people put their wishes into writing while they are healthy, often as part of their estate planning. Other people make advance directives when they are diagnosed with a life-threatening illness

Types of advance directives are:

A Living Will

A Health Care Surrogate Designation

What is a living will?

It is a written or oral statement of the kind of medical care you want or do to want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living. You may wish to speak to you health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

What is a health care surrogate designation?

It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

Am I required to have an advance directive under Florida law?

No, there is no legal requirement to complete an advance directive. However, if you have no made an advance directive, decisions about your health care may be made for you by your wife or husband, your adult child, your parent, your adult sibling, an adult relative, a close friend or a court-appointed guardian.

Must an attorney prepare the advance directive?

No, the procedures are simple and do not require an attorney.

An advance care directive needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or blood relative.

Where can I find advance directive forms?

They are available at your provider's office. Please inquire and we will provide one to you.

Can I change my mind after I write an advance directive?

Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated.

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ADVANCED DIRECTIVES FAQS continued

What if I have filled out an advance directive in another state and need treatment in Florida?

An advance directive completed in another state, as described in that state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?

If you designate a health care surrogate and an alternate surrogate, be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.

Provide a copy of your advanced care directives to your primary care provider.

Make sure your health care provider, attorney, and the significant people in your life know that you have an advance directive and where it is located. You also may want to give them a copy.

If you change your advance directive, make sure your health care provider, attorney, and the significant people in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your health care provider, attorney, or the significant people in your life.

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Patient Name: _____

DOB: _____

LIVING WILL DECLARATION

I, _____, being of sound mind, and after careful consideration, make this declaration that if I should become unable to make or communicate my own health care decisions, I direct my provider, my health care surrogate, and my family to honor this living will as my legal right. I understand that this living will only becomes effective when two providers have determined that I have any of the below:

- Have a terminal or end-stage condition or condition with little or no chance of recovery.
- Am in a persistent vegetative state and 2 providers have determined that there is no reasonable probability of recovery

I state the following instructions:

Cardio-pulmonary resuscitation (CPR) if my heart or breathing stops.	◯ Yes, I do want	◯ No, I do NOT want
A breathing machine if I am unable to breathe on my own.	◯ Yes, I do want	◯ No, I do NOT want
Nutrition and fluids through tubes in my veins, nose or stomach.	◯ Yes, I do want	◯ No, I do NOT want
Aggressive medical care such as kidney dialysis or surgery.	◯ Yes, I do want	◯ No, I do NOT want
Medications that can prolong my dying.	◯ Yes, I do want	◯ No, I do NOT want
I want comfort care.	◯ Yes, I do want	◯ No, I do NOT want

Other points that are important to my end of life wishes are: _____

_____

_____

I have read and understand this Living Will and designation of a Healthcare Surrogate, and I am freely and voluntarily signing it on ___/___/_____ in the presence of witnesses. At least one of these witnesses is not a spouse or blood relative.

Signed: _____

Street Address: _____

County: _____ City, State: _____

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Patient Name: _____

DOB: _____

APPOINTMENT OF MY HEALTH CARE SURROGATE

I, _____, appoint the following as my Heath Care Surrogate:

Name: _____

Address: _____

Phone: _____

If my surrogate is unable or unwilling my next choice (alternate Health Care Surrogate) is:

Name: _____

Address: _____

Phone: _____

I authorize my Health Care Surrogate to:

___ (initials) Receive any necessary health information, whether oral or recorded in any form or medium, that is created or received and relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.

___ (initials) Make all health care decisions for me, which means he or she has the authority to:

1. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
2. Apply on my behalf for private, public, government, or veterans' benefits to defray the cost of health care.
3. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
4. Decide to make an anatomical gift.

___ (initials) Specific instructions or restrictions: (if none put N/A)

_____

_____

_____

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Patient Name: _____

DOB: _____

While I have decision-making capacity, my wishes are controlling and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation.

To the extent I am capable of understanding, my Health Care Surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

This Health Care Surrogate Designation is not affected by my subsequent incapacity except as provided by law.

I understand that I may, at any time while I retain my capacity, revoke or amend this designation by:

1. Signing a written and dated instrument which expresses my intent to amend or revoke this designation
2. Physically destroying this designation through my own action or by thtat of another person in my presence and under my direction
3. Verbally expressing my intention to amend or revoke this designation
4. Signing a new designation that is materially different from this designation.

My Health Care Surrogate's authority become effective when my primary provider determines that I am unable to make my own health care decisions unless I initial either or both of the following:

If I initial here ___, my Health Care Surrogate's authority to receive my health information take effect immediately.

If I initial here ___, my Health Care Surrogate's authority to make health care decisions for me take effect immediately except that any instructions or health care decisions I make, either verbally or in writing, while I possess capacity shall supersede any instructions or health care decisions made by my surrogate that are in material conflict made by me.

(At least one of these witnesses cannot be a spouse or blood relative)

WITNESSES:

1. Printed Name: _____ Signature:_____

2. Printed Name: _____ Signature:_____