

# Vermont Advance Directive For Health Care

Prepared by the Vermont Ethics Network

## EXPLANATION AND INSTRUCTIONS

- *You have the right to give instructions about what types of health care you want or do not want.*
- *You also have the right to name someone else to make health care decisions for you when you are unable to make them yourself.*
- *You may do either of these by telling your family or your doctor, but it is generally better for you and your family if you write down your wishes.*
- *You may use this form in its entirety or you may use any part of it. For example, if you simply want to choose an agent in **Part One**, you may do so and go directly to **Part Five** to sign this in the presence of appropriate witnesses.*
- *You are also free to use a different form as long as it is properly signed and witnessed.*

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*Part One* of this form lets you name a person as your “**agent**” to make health care decisions for you if you become unable to make your own decisions. You may also name alternate agents. You should choose as your agent (and alternates) people you trust, who are going to be comfortable making what might be hard decisions on your behalf. They should know you and be guided by your values in making choices for you.

You should notify your agent and alternates that you have named them, and they need to agree to act as your agent if asked to do so. Your agent does not have authority to make decisions for you until you are unable to make your own decisions.

If you do not appoint an agent, and then become unable to make your own decisions, someone will be found to make health care decisions for you.

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*Part Two* of this form lets you state **Treatment Wishes**. Choices are provided for you to express your wishes about having, not having or stopping treatment necessary to keep you alive under certain circumstances. Space is also provided for you to write out any additional or specific wishes based on your values, health condition or beliefs.

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*Part Three* of this form lets you express your wishes about **organ or tissue donation**.

*Part Four is for you to express your wishes about autopsy and funeral arrangements.*

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*Part Five of this form is for signatures. You must sign and date the form in the presence of two witnesses. The following persons may not serve as witnesses: your agent and alternate agents; your spouse or partner; your heirs; your doctor (or doctor's employee); an employee or the owner of the residential care facility where you live; or any person to whom you owe money.*

*You should give copies of the completed form to your agent and alternate agents, to your physician, your family and to any health care facility where you reside or at which you are likely to receive care. You should keep a list of those who have copies in case you revoke or revise the document in the future. You have the right to revoke all or part of this advance directive for health care or replace this form at any time. If you do revoke it, all old copies should be destroyed.*

*You may wish to read the booklet **Taking Steps** that includes worksheets to help you think about and discuss different choices and situations with your agent or loved ones. You may also use this section to nominate a guardian of your person, should someone need to be appointed at some future time to make decisions for you. Also, if you have a specific illness or condition and wishes that relate to it, this is a good place to note that.*

# Advance Directive

MY NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ S.S # \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

## Part One: Appointment of My Health Care Agent

I appoint \_\_\_\_\_

ADDRESS \_\_\_\_\_

TEL. (DAY) \_\_\_\_\_ (EVENING) \_\_\_\_\_

CELLPHONE \_\_\_\_\_ 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. (DAY) \_\_\_\_\_ (EVENING) \_\_\_\_\_

CELLPHONE \_\_\_\_\_ 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.*

*The space below is to identify your doctor or health care provider (optional).*

PRIMARY CARE PHYSICIAN \_\_\_\_\_

ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_

OTHER HEALTH CARE PROFESSIONAL \_\_\_\_\_

ADDRESS \_\_\_\_\_ TELEPHONE \_\_\_\_\_

*It is encouraged that you and your doctor discuss this document.*

MY NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ S.S.# \_\_\_\_\_

**Part Two: Treatment Wishes**

Please express your preferences that follow by initialing or checking the statements. You may initial more than one choice. Draw a line through any statement you do not agree with. 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, if you are being treated in a New York or New Hampshire hospital.

\_\_\_\_\_ **A. My Choice is to Limit Treatment—**

*(Initial or check those statements below that you agree with)*

- \_\_\_\_\_ 1. I do not want to be kept alive if 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 do not want to be kept alive if I become unconscious or unaware of my surroundings and most doctors agree that I will never regain consciousness.
- \_\_\_\_\_ 3. I do not want to be kept alive if I become unable to think or act for myself (and won't get better).
- \_\_\_\_\_ 4. I do not want to be kept alive if 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 any of the situations I have initialed above occur, and if I am also 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.
- \_\_\_\_\_ 7. If any of the situations I have initialed above occur, and if I am also unable to swallow enough food and water to stay alive, I *do not* want food and water to be given to me by vein or feeding tube, however, I will accept medication for pain and agitation via an I-V line.
- \_\_\_\_\_ 8. Other specific instructions are as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ **B. My Choice is to Sustain Life—I want to be kept alive as long as possible through any means possible regardless of my condition or awareness.**

MY NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ S.S # \_\_\_\_\_

### 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 hasten 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. ***It is strongly encouraged that you talk with your family and your health care agent about your wishes regarding organ donation.*** (Initial below all that apply.)

\_\_\_\_\_ I do **not** wish to be an organ donor.

\_\_\_\_\_ I wish to donate the following organs and tissues:

\_\_\_\_\_ any needed organs

\_\_\_\_\_ major organs (heart, lungs, kidneys, etc.)

\_\_\_\_\_ tissues such as skin and bones

\_\_\_\_\_ eye tissue such as corneas

\_\_\_\_\_ 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.)

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

MY NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_ S.S # \_\_\_\_\_

**Part Four: My Wishes for Burial or Disposal of My Remains Following My Death**

(Initial below all that apply.)

\_\_\_\_\_ A funeral followed by a burial in a casket at the *following location, if possible (please tell us where the burial plot is located and whether it has been pre-purchased):*

\_\_\_\_\_

\_\_\_\_\_ Cremation and my ashes buried or distributed as follows:

\_\_\_\_\_

\_\_\_\_\_ A low cost alternative to a traditional funeral.

\_\_\_\_\_ Funeral arrangements as determined by my agent or family.

I have made pre-need contract 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 being signed by that person as a free and voluntary act. Appointed agents, family members, health care providers and anyone to whom you owe money may not be witnesses.

WITNESS (AND ADDRESS) \_\_\_\_\_

\_\_\_\_\_

WITNESS (AND 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, probate court designee):

NAME \_\_\_\_\_ TITLE/POSITION \_\_\_\_\_

ADDRESS \_\_\_\_\_ DATE \_\_\_\_\_

**Important!**

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

\_\_\_\_ Vermont Advance Directive Registry (anticipated available by 2006)

\_\_\_\_ Health care agent

\_\_\_\_ Alternate health care agent

\_\_\_\_ Family members: (name and address of all who have copies)

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_ MD

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

\_\_\_\_ Hospital(s) NAME \_\_\_\_\_

\_\_\_\_ Other individuals or locations: *(use additional sheet if needed)*

NAME \_\_\_\_\_ ADDRESS \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_