**Vermont Advance Directive for Health Care**

END-OF-LIFE TREATMENT WISHES

If the time comes when I am close to death or am unconscious and unlikely to become conscious again (choose and initial all that apply):

1. \_\_\_\_\_ I do want all possible treatments to extend my life.

OR

2. \_\_\_\_\_ I do not want my life extended by any of the following means:

\_\_\_\_\_ breathing machines (ventilator or respirator)

\_\_\_\_\_ tube feeding (feeding and hydration by medical means)

\_\_\_\_\_ antibiotics

\_\_\_\_\_ other medications whose purpose is to extend my life

\_\_\_\_\_ any other means

\_\_\_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_ I want my agent to decide what treatments I receive, including tube feeding.

4. \_\_\_\_\_ I want care that preserves my dignity and that provides comfort and relief from symptoms that are bothering me.

5. \_\_\_\_\_ I want pain medication to be administered to me even though this may have the

unintended effect of hastening my death.

6. \_\_\_\_\_ I want hospice care when it is appropriate in any setting.

7. \_\_\_\_\_ I would prefer to die at home if this is possible.

8. Other wishes and instructions (state below or use additional pages):

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

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OTHER TREATMENT WISHES

If certain statements in this section do not concern or apply to you, do not feel you have to address them. Choose and initial all that apply:

1. \_\_\_\_\_ I wish to have a Do Not Resuscitate (DNR) Order written for me.

2. \_\_\_\_\_ If I am in a critical health crisis that may not be life-ending and more time is needed to determine if I can get better, I want treatments started. If, after a reasonable period of time, it becomes clear that I will not get better, I want all life extending stopped. This includes the use of breathing machines or tube feeding.

3. If I am conscious but become unable to think or act for myself and will likely not improve, I do not want the following life-extending treatment:

\_\_\_\_\_ breathing machines (ventilators or respirators)

\_\_\_\_\_ feeding tubes (feeding and hydration by medical means)

\_\_\_\_\_ antibiotics

\_\_\_\_\_ other medications whose purpose is to extend life

\_\_\_\_\_ any other treatment to extend my life

\_\_\_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_ If the likely costs, risks and burdens of treatment are more than I wish to endure, I do not want life-extending treatment. The costs, risks and burdens that concern me the most are:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_ If it is determined that I am pregnant at the time this Advance Directive becomes effective, I want:

\_\_\_\_\_ all life sustaining treatment.

OR

\_\_\_\_\_ only the following life sustaining treatments:

\_\_\_\_\_ breathing machines (ventilators or respirators)

\_\_\_\_\_ feeding tubes (feeding and hydration by medical means)

\_\_\_\_\_ antibiotics

\_\_\_\_\_ other medications whose purpose is to extend life

\_\_\_\_\_ any other treatment to extend my life

\_\_\_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6. Hospitalization — If I need care in a hospital or treatment facility, the following facilities are listed in order of preference:

Hospital/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for preference: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I would like to Avoid being treated in the following facilities:

Hospital/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital/Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. I prefer the following medications or treatments: Use more space or additional sheets for this section, if needed.

Avoid use of the following medications or treatments: (List medications/treatments)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ORGAN AND TISSUE DONATION

I want my agent (if I have appointed one) and all who care about me to follow my wishes about organ donation if that is an option at the time of my death. (Choose and initial below all that apply.)

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

\_\_\_\_ any needed organs or tissues

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

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

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

\_\_\_\_ I wish my agent to make any decisions for anatomical gifts (or)

\_\_\_\_ I wish the following person(s) to make any decisions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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

SIGNED DECLARATION OF WISHES

I declare that this document reflects my desires regarding my future health care and that I am signing this Advance Directive of my own free will.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, County, State of Residence: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WITNESSES

(There must be two adult witnesses. Neither witness can be the Principal’s spouse, agent, brother, sister, child, grandchild or reciprocal beneficiary.)

Acknowledgement of Witnesses — I affirm that the Principal appears to understand the nature of an Advance Directive and to be free from duress or undue influence.

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If applicable, this third witness is if the Principal is in a hospital, nursing home or residential care facility when completing this Advance Directive.)

Acknowledgement by the person who explained this Advance Directive if the principal is a current patient or resident in a hospital, or other health care facility.

I affirm that:

* the maker of this Advance Directive is a current patient or resident in a hospital, nursing home or residential care facility,
* I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in Vermont, or a probate court or hospital designee, and
* I have explained the nature and effect of the Advance Directive to the Principal and it appears that the Principal is willingly and voluntarily executing it.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title/position: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_