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ADVANCE DIRECTIVE

Your Durable Power of Attorney for Health Care, Living Will and Other Wishes

This document has been prepared and distributed as an informational service of the District of Columbia Hospital Association.

INSTRUCTIONS AND DEFINITIONS

Introduction:
This form is a combined durable power of attorney for health care and living will for use in D.C., Maryland and Virginia. With this form, you can:

- Appoint someone to make medical decisions for you if you, in the future, are unable to make those decisions for yourself.
- Indicate what medical treatment you do or do not want if, in the future, you are unable to make your wishes known.

Directions:

- Read each section carefully.
- Talk to the person you plan to appoint to make sure that he/she understands your wishes and is willing to take the responsibility.
- Place the initials of your name in the blank before those choices you want to make.
- Fill in only those choices that you want under parts 1, 2 and 3. Your advance directive should be valid for whatever part(s) you fill in as long as it is properly signed.
- Add any special instructions in the blank spaces provided. You can write additional comments on a separate piece of paper but you should indicate on the form that there are additional pages to your advance directive.
- Sign the form and have it witnessed.
- Give to your family and anyone else who might be involved in your care a copy of your advance directive and discuss it with them.
- Understand that you may change or cancel this document at any time.

WORDS YOU NEED TO KNOW

Advance Directive: A written document that tells what a person wants or does not want if he/she in the future can't make his/her wishes known about medical treatment.
Artificial Nutrition and Hydration: When food and water are fed to a person through a tube.
Autopsy: An examination done on a dead body to find the cause of death.
Comfort Care: Care that helps to keep a person comfortable but does not make him/her better. Bathing, turning, and keeping a person's lips moist are types of comfort care.
CPR (Cardiopulmonary Resuscitation): Treatment to try to restart a persons breathing or heartbeat. CPR may be done by pushing on the chest, by putting a tube down the throat, or by other treatment.
Durable Power of Attorney for Health Care: An advance directive that appoints someone to make medical decisions for a person if in the future he/she can't make his or her own medical decisions.
Life-Sustaining Treatment: Any medical treatment that is used to keep a person from dying. A breathing machine, CPR and artificial nutrition and hydration are examples of life-sustaining treatments.
Living Will: An advance directive that tells what medical treatment a person does or does not want if he/she is not able to make hi/her wishes known.
Organ and Tissue Donation: When a person permits his/her organs (such as eyes or kidneys) and other parts of the body (such as skin) to be removed after death to be transplanted for use by another person or to be used for experimental purposes.

Persistent Vegetative State: When a person is unconscious with no hope of regaining consciousness even with medical treatment. The body may move and eyes may be open but as far as anyone can tell, the person can't think or respond.
Terminal Condition: An on-going condition caused by injury or illness that has no cure and from which doctors expect the person to die even with medical treatment. Life-sustaining treatments will only prolong a person's dying if the person is suffering from a terminal condition.

D.C., Maryland and Virginia

ADVANCE DIRECTIVE
Your Durable Power of Attorney for Health Care, Living Will and Other Wishes

I, _____ write this document as a directive regarding my medical care.

Put the initials of your name by the choices you want.

PART 1. MY DURABLE POWER OF ATTORNEY FOR HEALTH CARE

_____I appoint this person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself:

NAME_____PHONE: HOME _____WORK_____

ADDRESS_____

_____

If the person above can't or will not make decisions for me, I appoint this person:

NAME_____PHONE :HOME_____WORK_____

ADDRESS_____

_____

_____I have not appointed anyone to make health care decisions for me in this or any other document.

I want the person I have appointed, my doctors, my family, and others to be guided by the decisions I have made below:

PART 2. MY LIVING WILL

These are my wishes for my future medical care if there ever comes a time when I can't make these decisions for myself.

A. These are my wishes if I have a terminal condition:

Life-Sustaining Treatments

_____ I do not want life-sustaining treatments (including CPR) started. If life-

sustaining treatments are started, I want them stopped.
_____ I want life-sustaining treatments that my doctors think are best for me.
_____ Other wishes: _____

Artificial Nutrition and Hydration
_____ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is strated, I want it stopped.
_____ I want artificial nutrition and hydration even if it is the main treatment keeping me alive.
_____ Other wishes: _____

Comfort Care
_____ I want to be kept as comfortable and free of pain as possible, even if such care prolongs my dying or shortens my life.
_____ Other wishes: _____

B. These are my wishes if I am ever in a persistent vegetative state:
Life-Sustaining Treatments
_____ I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.
_____ I want life-sustaining treatments that my doctors think are best for me.
_____ Other wishes:_____

Artificial Nutrition and Hydration
_____ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.
_____ I want artificial nutrition and hydration even if it is the main treatment keeping me alive.
_____ Other wishes:_____

Comfort Care
_____ I want to be kept as comfortable and free of pain as possible even if such care prolongs my dying or shortens my life.
_____ Other wishes: _____

C. Other Directions
You have the right to be involved in all decisions about your medical care, even those not dealing with terminal conditions or persistent vegetative states. If you have wishes not covered in other parts of this document please indicate them here:
_____
_____

PART 3. OTHER WISHES
A. Organ Donation

_____ I do not wish to donate any of my organs or tissues.
_____ I want to donate all of my organs and tissues.
_____ I only want to donate these organs and tissues:_____
_____ Other wishes:_____

Autopsy

_____ I do not want any autopsy.
_____ I agree to an autopsy if my doctors wish it.
_____ Other wishes:_____

If you wish to say more about any of the above choices, or if you have any other statements to make about your medical care, you may do so on a separate sheet of paper. If you do so, put here the number of pages you are adding:____

PART 4. SIGNATURE

You and two witnesses must sign this document for it to be legal.

A. Your Signature

By my signature below I show that I understand the purpose and the effect of this document.

NAME_____DATE_____

ADDRESS_____

B. Your Witnesses' Signature

I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence, and that he/she appears not be acting under pressure, duress, fraud or undue influence. I am not related to the person making this advance directive by blood, marriage or adoption, nor, to the best of my knowledge am I named in his/her will. I am not the person appointed in this advance directive. I am not a health care provider or an employee of health care provider who is now, or ahs been in the past, responsible for the care of the person making this advance directive.

Witness#1

NAME_____DATE_____

ADDRES_____

Witness#2

NAME_____DATE_____

ADDRESS_____