Advance Directives

It's your life. You decide.

UFHealth
UNIVERSITY OF FLORIDA HEALTH

Who will speak for you?

Life happens. Accidents happen.

What do you want to happen if you become unable to make your own medical decisions?

You're not too young to start thinking about preparing an advance directive. Make your choices known.

Notes:

_____

_____

_____

_____

_____

Advance Directive Notification Card

The card below may be used as a convenient method to inform others of your Advance Directives. Complete the card and cut it out. Place it in your wallet or purse. You can also make copies and place another one on your refrigerator, in your car glove compartment, or other, easy to find place. *(Note: The person listed as your emergency contact does not have to be your Health Care Surrogate. The Surrogate is the person you choose to speak for you if you are unconscious or otherwise unable to speak for yourself.)*

Fold here

Advance Directive Notification

I, _____ have created
print name

the following Advance Directives:

- ☐ Living Will
- ☐ Designation of Health Care Surrogate
- ☐ Anatomical Donation
- ☐ Other *(specify)* _____

_____

If I am unable to speak for myself, please contact:

(May, but need not be your Healthcare Surrogate)

_____
Health Care Surrogate *Number*

_____
Emergency Contact *Number*

_____
Emergency Contact *Number*

Advance directives

What is an advance directive?

An advance directive lets you indicate who you would want to make decisions for you if you are unable to make them for yourself. It also lets you say exactly how you wish to be treated if you become seriously ill and cannot speak for yourself.

Advance directives include a living will and the designation of a health care surrogate.

How can an advance directive help you and your family?

Completing an advance directive helps guide conversations with your family, friends and physicians about how you want to be treated if you become seriously ill. In addition, your family members will not have to guess what you would want, because an advance directive makes your choices clear when you cannot speak for yourself.

Who should consider having an advance directive?

Everyone age 18 or older is encouraged to prepare an advance directive.

Do I need a lawyer to help me prepare an advance directive?

No, but a lawyer might be helpful.

Health care surrogate

Who is a health care surrogate and when does the designation take effect?

Your health care surrogate is a person you authorize via a Designation of Health Care Surrogate form to make medical decisions for you. With the most common Designation of Health Care Surrogate, the authority of the Surrogate begins when you are unable to make your own decisions. However, you may authorize a Surrogate to make decisions for you, even if you are still able to make decisions for yourself. If you choose to allow your Surrogate to make decisions for you while you are still able to make them for yourself, and your surrogate's decision is different than what you want, your decision is still controlling.

It is important that you discuss your choices in advance with your health care surrogate. If your health care surrogate does not know the decisions you would have made, he or she should make decisions based on what is in your best interest.

Who can be a health care surrogate?

Any competent adult who (person 18 or older) can be your health care surrogate. Ask that person whether he or she agrees to act for you before you complete your advance directive. You may also want to choose a second person as an alternate in case your first choice is unavailable or otherwise unable to make decisions on your behalf. If you appoint your spouse as your health care surrogate and you later divorce, the appointment of your spouse is revoked unless you say otherwise in your advance directive.

Does my Designation of Health Care Surrogate form have to be signed and witnessed?

Yes, you must sign and date the form or have someone else sign for you in your presence and at your direction if you are unable to sign. It must also be witnessed by two adults. Neither witness can be your designated surrogate, and at least one witness cannot be your spouse or a blood relative.

Health care surrogate *(continued)*

If you do not name a Health Care Surrogate,

Florida law directs your doctor to choose someone from the following list to make choices for you when you cannot in the following order of priority:

- **Guardian** (only if one has been appointed by a court)
- Your **spouse**
- Your **adult child** or **children**
- Your **parent** or **parents**
- Your **adult brothers and sisters**
- Another **relative** who knows you well enough to know what you would want
- A **friend** who knows you well enough to know what you would want
- If you have none of the above, a social worker not employed by the hospital may be approved by your hospital's ethics committee to make decisions after speaking with your doctor(s)

Designation of Health Care Surrogate

I, _____ *(please print)* want _____
Print Name *Surrogate's Name*

Phone _____ Address _____

to be my Health Care Surrogate and make health care decisions for me as indicated by my initials below:

_____ Effective only when my physician determines that I am unable to make these decisions myself.

_____ Effective immediately, with the understanding that while I have decision-making capacity, my choices are controlling and my health care providers must clearly communicate any treatment plan and health care decisions to me.

If the above person is unwilling, unable, or not reasonably available to make these decisions on my behalf, **I want**

_____ Phone _____ Address _____
Alternate Surrogate's Name

to be my alternate Health Care Surrogate.

I understand that, unless I note in the additional instructions space provided below, my Health Care Surrogate will be able to:

- Give, or refuse informed consent for my medical care
- Make end of life decisions for me
- Apply for public benefits to help pay for the cost of my care
- Give permission for me to be admitted to or transferred from a health care facility
- Obtain all health information – past, present and future – needed to make health care decisions for me and to apply for public benefits to pay for the cost of my care
- Give permission for the release of health information to provide for my health care
- Make a donation of all or part of my body after my death for transplantation therapy, research or education

Additional Instructions: _____

Additional Consent (if applicable):
I understand that my Health Care Surrogate **cannot** consent to any of the following for me unless I allow him/her to do so by placing my initials in the space provided.

_____ Experimental treatments that have not been approved as research under federal law.

_____ Refusal of life-prolonging procedures if I am pregnant with a fetus that cannot survive outside the womb.

_____ Abortion

_____ Sterilization

I understand that my Health Care Surrogate **cannot** admit me to a psychiatric facility, or consent to psychiatric treatment or procedures for me, without the permission of a court.

I am competent and I understand the importance of this Designation, and sign it in the presence of my two witnesses.

Signature _____ Date _____

Witness _____ Witness _____
Print Name *Print Name*

_____ _____
Signature *Signature*

Address _____ Address _____

Phone _____ _____ Phone _____ _____

Please Note: Only one of the witnesses can be your husband, wife or blood relative. Your surrogate(s) cannot be a witness.

UFHealth SHANDS

AD0001

Patient Name:	Patient Identification #:

Revised 3/7/17
PS121459

Living will

What is a living will?

A written or verbal statement that expresses your choices regarding the type of medical care you choose to receive, including life-prolonging procedures and treatments, if your doctor and another agreeing doctor find that you have a terminal illness, a persistent vegetative state or an end-stage condition. Your living will must have two witnesses, one of whom cannot be your spouse or blood relative. Your living will does not need to be notarized, but you must sign and date it. If you are unable to sign you can direct someone to sign for you, in your presence.

What are life-prolonging procedures or treatments?

Procedures or treatments that are not expected to cure your terminal condition, but can artificially delay death. (For example, cardiopulmonary resuscitation (CPR) or hemodialysis.)

What is a terminal illness?

A condition caused by injury, disease or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

What is a persistent vegetative state?

A permanent and irreversible condition of unconsciousness in which there is the absence of voluntary action or cognitive behavior of any kind and/or the inability to communicate or to interact purposefully with the environment.

What is an end-stage condition?

An irreversible condition caused by injury, disease or illness that has resulted in progressively severe and permanent deterioration and for which, to a reasonable degree of medical probability, treatment would be ineffective.

Living Will Declaration

I, _____, hereby state my wishes about procedures to artificially prolong my dying (also called life-prolonging procedures) in certain situations.
Print Name

If I am unable to make informed medical decisions for myself and I am found to be in any of the conditions that I note with my initials below, I want life-prolonging procedures to be withheld or stopped if such procedures have little or no chance of curing me or helping me recover from the condition, but would only serve to artificially prolong my dying. **In other words, I want to be allowed to die naturally, with only treatments that will keep me comfortable and relieve pain.**

(Place your initials by every condition that you want this Living Will to apply to. If you do not place your initials in a blank and you are in that condition you will receive life-prolonging procedures for that condition.)

_____ I have a condition caused by injury, disease or illness that is expected to cause death (also called a terminal condition)

_____ I am in a permanent state of unconsciousness (also called a permanent vegetative state)

_____ I have a condition caused by injury, disease or illness that has resulted in progressively severe and permanent deterioration (also called an end-stage condition)

If I cannot eat or drink naturally (by mouth) and giving me food and water artificially would serve only to prolong my dying:

_____ I DO want
- _____ food (nutrition)
- _____ water (hydration)

_____ I DO NOT want
- _____ food (nutrition)
- _____ water (hydration)

In the event that I suffer cardiac or respiratory arrest (that is, I stop breathing or my heart stops beating):

_____ I DO want
- _____ CPR (compressions/defibrillation/ resuscitation medications)
- _____ to be intubated (tube in lungs to help me breathe)

_____ I DO NOT want
- _____ CPR (compressions/defibrillation/ resuscitation medications)
- _____ to be intubated (tube in lungs to help me breathe)

I give these directions after careful thought and in keeping with my convictions and beliefs. I expect my family, doctor, and others concerned with my care to abide by my wishes and respect my legal right to refuse medical care.

OPTIONAL **Instructions that may help your doctor know exactly what your wishes are:** I also make the following instructions on specific treatments that I do or do not want, and/or conditions that are important to me. (Use additional paper if necessary; sign, date and have witnesses sign the additional sheets.)

Additional Instructions: _____

_____

OPTIONAL: I want the following person to act on my behalf to see that the provisions of this Living Will are carried out:

Name _____ Address _____ Phone _____ _____

I am competent and I understand the importance of this Declaration, and sign it in the presence of my two witnesses.

Signature _____ Date _____

Witness _____ Witness _____
Print Name *Print Name*

_____ _____
Signature *Signature*

Address _____ Address _____

Phone _____ _____ Phone _____ _____

Please Note: Only one of the witnesses can be your husband, wife or blood relative. Your surrogate(s) cannot be a witness.

UFHealth SHANDS

AD0001

Patient Name: Patient Identification #:

Revised 3/14/17
PS121460

Your personal choices

It is important to communicate your choices to loved ones prior to a significant medical event or end-of-life care. Sharing your thoughts and concerns about end-of-life with your health care surrogate or loved ones allows them to understand your personal choices. Examples of things you may want to think about:

- Where and how you might want to spend your final days – home/hospital/nursing home?
- Life-support treatment that you may/may not want such as cardiopulmonary resuscitation (CPR), major surgery, blood transfusions, dialysis, antibiotics
- Your preferences for medication if you are in pain – it may affect your ability to interact with your loved ones
- The importance of personal care like massage, nail clipping, shaving, as long as they do not cause pain or discomfort
- Specific religious or personal beliefs/practices that you want honored
- Other considerations: _____

  _____

What are your thoughts about Organ Donation?

Organ or Tissue Donation

You may wish to consider donating, at death, all or part of your body for transplantation, research or education. An organ donation form is a document that expresses your choices.

Information about organ and tissue donation is available at the Agency for Health Care Administration's website www.fdhc.state.fl.us (Click on "Site Index," then scroll down to "Organ Donors") or the federal government site www.organdonor.gov.

If you are interested in donating your body, please call the Anatomical Board to make arrangements. Call 1.800.628.2594 or 352.392.3588 or visit the website for more information at www.med.ufl.edu/anatbd

To learn more, please be sure to talk further with your health care provider.

Organ Donation Form

I, _____ *(Check only 1 of 3 following options.)*

1. _____ have recorded my wishes for donation on the donor registry of _____.

OR

2. _____ hereby make the anatomical gifts noted with my initials below, to take effect on my death. ***(Initial all that apply)***

   a. ___ any needed organs for the purpose of

      ____ transplantation

      ____ medical research or education

   b. ___ my eyes for the purpose of

      ____ transplantation

      ____ medical research or education

   c. ___ any needed tissues for the purpose of

      ____ transplantation

      ____ medical research or education

   d. ___ only the following organs and/or tissues for the purpose of transplantation:

      _____

   e. ___ only the following organs and/or tissues for the purpose of medical research or education:

      _____

OR

3. _____ wish to donate my whole body for anatomical study. *Donation of your body for anatomical study means you cannot donate any organs, tissues, eyes or other body parts for transplants, education or research above.* **To complete a donation of your whole body for anatomical study, you must contact the Anatomical Board of the State of Florida by calling 1-800-628-2594 or 352-392-3588 for further instructions and the appropriate additional forms.**

Limitations or special wishes, if any: _____

_____

Signed by the donor and the following witnesses in the presence of each other, *except that Option 1 does not require witnesses to the donor's signature:*

_____ *Donor's Signature*

_____ *Donor's Date of Birth*

_____ *Date Signed*

First Witness:

Signature _____ Date _____

Print Name _____

Address _____

_____

Phone _____ _____

Second Witness:

Signature _____ Date _____

Print Name _____

Address _____

_____

Phone _____ _____

UFHealth SHANDS

AD0001

Patient Name: Patient Identification #:

Revised 3/14/17
PS121461

Resources

Where can I find forms and other resources for preparing an advance directive?

- **UFHealth.org/advance-directives**
- **aarp.org** (Type "advance directives" in the website's search engine)
- **agingwithdignity.org** Phone: (1.888.594.7437)
- **aha.org/putitinwriting**
- **caringinfo.org**
- **myemmi.com/self-reg/A**
- **floridabar.org**
- **FloridaHealthFinder.gov**
- **nhdd.org**
- **theconversationproject.org**

Please provide a copy of the completed documents to your doctor, spiritual counselor, attorney, loved ones and/or health care surrogate.

To have your documents entered in your UF Health medical record:
Provide a copy to your UF Health Clinic Provider at your next appointment ***or***
Scan the document into MyUFHealth (see instructions at mychart.shands.org) ***or***
follow the instructions below, based on where you receive services:

Gainesville Area	Jacksonville Area
Take a copy to the Admissions area of UF Health Shands Hospital and place it in the red bin for Medical Records to scan into your record or fax to 352.627.4371 ***or*** Mail a copy to: **UF Health Information Management Department** **4002 NW 22nd Drive** **Gainesville, FL 32605**	Take a copy to the 1st Floor Clinical Center Admissions area located at: **655 West 8th Street** **Jacksonville, FL 32209** ***or*** Take a copy to the 1st Floor North Campus Admissions area located at: **15255 Max Leggett Parkway** **Jacksonville, FL 32218**

Questions? Email us at advdir@shands.ufl.edu

UFHealth

UNIVERSITY OF FLORIDA HEALTH