Advance Directive

What is an advance directive?

An **advance directive** lets you say what **health care choices you do** or **don't want** if you cannot speak for yourself. It can also let you name a person who you want to make choices for you if you are unable to make them for yourself.

Advance directives include the designation of a health care surrogate.

Who is a health care surrogate and when do they take effect?

Your **health care surrogate** is a person you pick to make health care choices for you. You can do this by signing a **'Designation of Health Care Surrogate'** form. You can have your surrogate make health care choices for you only when you are unable to make them for yourself. Or, you may decide you would like your surrogate to make choices for you even while you are still able to make them for yourself. If you choose this option, and your surrogate's choice is not what you want, your doctor will follow your – not your surrogate's – decision.

It is important that you discuss your choices early on with your health care surrogate. If they do not know the choices you would want, they will make choices based on what they think is best.

Who can be a health care surrogate?

Any **capable adult** (age 18 or older) can be your **health care surrogate**. Ask that person whether they agree to act for you before you fill out the form. You may also want to choose a second person in case your doctor cannot contact the first person to make choices for you. If you name your spouse as your health care surrogate and you later divorce, your spouse is no longer your surrogate unless you say so 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. If you are unable to sign, have someone else sign for you in your presence. It must also be witnessed by two adults. Neither witness can be your surrogate, and at least one witness cannot be your spouse or related to you. You may complete the enclosed form today.

Resources

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

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

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 a copy to:* 352.627.4371 *or

Mail a copy to:
UF Health Information
Management Department
4002 NW 22nd Drive
Gainesville, FL 32605

JACKSONVILLE AREA

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

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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 wishes known.

UFHealth
UNIVERSITY OF FLORIDA HEALTH

Prepare an advance directive.
Learn more at UFHealth.org/advance-directives

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

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Patient Name:	Patient Identification #:

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