Advance Health Care Directive

Name_____

You have the choice to make your own health care decisions and choose someone to make health care decisions for you if you cannot. This form will let you do EITHER or BOTH of these things. Filling out this form is your choice. You may change, cross out or add your own words to any part of this directive, including my choice of Health Care Agent. The form must be signed, dated and witnessed or notarized to meet the Alaska requirements for an Advance Health Care Directive.

Part I: Health Care Agent

If I cannot make my own health care decisions/choices, I trust the following person(s) to make my health care choices for me. This person is at least 18 years of age and is NOT my health care provider or employed by my health care provider (unless related by birth, marriage or adoption).

My Health Care Agent is my (relationship): _____

Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

If the above person is not willing or able to speak for me, I choose the following person as my Alternate Health Care Agent.

My Alternate Health Care Agent is my (relationship): _____

Alternate Name: _____ Phone: _____

Address: _____ City/State/Zip: _____

To the extent allowed by Alaska law, (unless crossed out below) my Health Care Agent has the right to:

1. Make all health care decisions for me, this includes the ability to consent to or refuse any medical care, treatment, service or procedure for any physical or mental condition, including:
   - Diagnostic tests, medications or surgery
   - Administration or discontinuation of behavioral health (psychotropic) medication
   - Providing, withholding, or withdrawing artificial nutrition and hydration
   - Move me to an assisted living home, nursing facility, hospice or hospital
   - Hire or fire health care workers to provide the best care for me
   - Do not resuscitate orders
2. See and approve release of my medical records and personal papers.
3. Donate my organs or tissues, as allowed by the State of Alaska.
4. Apply for medical financial aid programs, such as Medicaid and Medicare or other benefits for me.
5. My Health Care Agent will make medical choices for me based on my best interests. These wishes are based on instructions that I have given in this form or what I have told him/her is important to me.

Name: _____ Date of Birth: _____

Part II: Instructions for Health Care

If a time comes that I am very sick and not able to make my own health care choices or decisions, I want my medical providers and Health Care Agent to respect and follow my wishes as they are written here even if they are different than his or her own. I understand that whatever my health care choices are, I will get the best care possible. I understand that I can change, cross-out, or add to these instructions at any time.

If I have a serious injury or illness that cannot be cured, the following is most important to me (**check** the **one** that matters most to **you**):

☐ The **length of my life** is most important to me even if it means I need extended intensive care and life support, as long as it is medically appropriate.

OR

☐ The **quality of my life** is most important to me. I wish to avoid extended intensive care and life support.

Comments: _____

If I have a serious injury or illness that cannot be cured, I would **not** want my life prolonged if (you may **check more than one**):

☐ I'm not able to care for myself (feed, bathe, toilet and dress without help).

☐ I can't think clearly or make my own decisions.

☐ I don't recognize or can't interact with my loved ones.

☐ I'm showing signs of suffering that cannot be relieved.

Other: _____

My medical preferences at the end of my life are (**check** the **one** that matters most to **you**):

☐ If possible, I wish to spend the last days of my life at home or in a home-like setting where I can be cared for by family and friends.

OR

☐ If possible, I wish to spend the last days of my life in the hospital or a medical home.

OR

☐ Let my Health Care Agent decide.

Name: _____ Date of Birth: _____

Part II: Instructions for Health Care (Continued)

In the last days of my life, these are important things to know (examples include personal messages, sharing ways to care, music to play, people you wish to see and/or spiritual practices/readings):

_____

_____

_____

After my death (**check** the **one** that matters most to **you**):

☐ I want to donate any needed organs, tissues, or body parts:

☐ I want to donate only the following organs, tissues, or body parts: _____

☐ I do not want to donate any of my organs, tissues, or body parts.

☐ Let my Health Care Agent decide.

After my death I want (**check** the **one** that matters most to **you**):

☐ To be buried.

☐ To be cremated.

☐ I want my loved ones to decide.

I want my final resting place to be: _____

_____

Cardiopulmonary Resuscitation (CPR)

In the event that my heart stops beating and my breathing stops (**check** the **one** that matters most to **you**):

☐ I want CPR. I want to try to be resuscitated no matter how sick or injured I am.

OR

☐ I want CPR unless I have any of the following:

- An injury or illness that cannot be cured, and I am dying
- No reasonable chance for surviving my illness or injury
- Little chance for survival and my medical providers think CPR would be more harmful than helpful

OR

☐ I do not want CPR. If my heart stops beating or my breathing stops, I wish to allow natural death.

Name: _____ Date of Birth: _____

Part II: Instructions for Health Care (Continued)

Life Support Treatments

Life support treatments include any medical test, blood product, surgery, procedure, machine and/or medicine needed to prolong life.

In the event that I am unable to speak for myself or make my own decisions:

- And/or have an incurable or irreversible condition that will result in my death
- And/or I'm unconscious and not expected to wake up
- And/or the harm of medical treatment would cause more suffering than good

(**check** the **one** that matters most to **you**)

☐ I want life support treatments to help me live as long as possible when medically appropriate.

OR

☐ I want to try life support treatments to see if I will get better, but I want them stopped if I am not getting better or it is clearly adding to my suffering.

OR

☐ I do not want life support treatments. I wish to allow natural death with medical treatments focused on providing comfort only.

Other wishes: _____

_____

Artificial Nutrition

In the event that I am unable to communicate or speak for myself and I am not able to eat food or drink fluids safely on my own (**check** the **one** that matters most to **you**):

☐ I want artificial nutrition when medically appropriate, unless it is clearly adding to my suffering.

☐ I want to try artificial nutrition for a short time to see if my condition improves, but I want it stopped if I am not getting better.

☐ I do not want artificial nutrition.

Other wishes: _____

_____

Name: _____ Date of Birth: _____

Making Your Advance Health Care Directive Legal

Do not sign your Advance Health Care Directive until you are in front of **both witnesses** or a Notary Public.

I ask that my Advance Health Care Directive is honored and respected by my family, friends, health care providers and Health Care Agent to the best of their ability within the laws of the State of Alaska. This Advance Health Care Directive is to be used if/when I am no longer able to make my own medical decisions or speak for myself. I understand my health care rights and choices, and I am signing this Advance Health Care Directive without stress or influence from others. Any Advance Health Care Directive I have done before this date is no longer valid.

Signature: _____ Date of Birth: _____

Address: _____ Phone: _____

Fill this out if using witnesses to validate directive (two witnesses needed if not notarized):

I, the witness, personally know the person who filled out this Advance Health Care Directive, and I am **not the person's Health Care Agent**. The above person has signed this paper in my presence, and he/she appears to be clear thinking and without stress or influence from others.

As a witness, I am over 18 years of age and I am not:

- A Health Care Agent listed on this Advance Health Care Directive
- A health care provider who takes care of this person
- An employee of this person's health care provider or health clinic

In addition at least one of the witnesses is not:

- Related by blood, marriage or adoption
- Entitled to this person's money, property, shares or permits

Signature of witness: _____

Printed name of witness: _____

Phone: _____

Address: _____

Address: _____

Date: _____

Signature of witness: _____

Printed name of witness: _____

Phone: _____

Address: _____

Address: _____

Date: _____

Or signed by Notary Public:

State of Alaska _____Judicial District

On this _____day of _____, in the year 20_____, before me, _____ (name of notary public) appeared _____, known to me (or satisfactorily proven) to be the person whose name is subscribed to this document and that they freely and voluntarily executed it.

My Commission Expires: _____

Notary Public:_____ (Seal)

Adapted from the form produced by Alaska Native Tribal Health Consortium, Alaska Native Medical Center, Palliative Care. Additional copies are available at: anmc.org/services/anthc-palliative-care