INSERT YOUR NAME

APPOINTMENT OF HEALTH CARE AGENT

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

ADD YOUR AGENT'S NAME, PHONE NUMBER, RELATION TO YOU, AND ADDRESS

Agent:

Name:_____ Phone #: _____

Relation: _____

Address: _____

_____

ADD YOUR ALTERNATE AGENT'S NAME, PHONE NUMBER, RELATION TO YOU, AND ADDRESS

Alternate Agent:

Name:_____ Phone #: _____

Relation: _____

Address: _____

_____

ADD ANY LIMITATIONS OR INSTRUCTIONS YOU HAVE FOR YOUR AGENT

Other Instructions or Limitations for my Agent:

_____

_____

_____

_____

_____

_____

_____

INSERT YOUR NAME

QUALITY OF LIFE STATEMENT

CHECK THE BOXES FOR CONDITIONS THAT YOU DO NOT CONSIDER AN ACCEPTABLE QUALITY OF LIFE

YOU CAN CHECK AS MANY OF THESE ITEMS AS YOU WANT, OR ADD ADDITIONAL CONDITIONS IN THE "OTHER INSTRUCTIONS" SECTION BELOW

TREATMENT INSTRUCTIONS

CHECK THE "YES" BOXES IF YOU WANT TO RECEIVE THE TREATMENT

CHECK THE "NO" BOXES IF YOU DO NOT WANT TO RECEIVE THE TREATMENT

INDIVIDUAL INSTRUCTION

I, _____, hereby give these individual instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. I do not consider the following conditions to be an acceptable quality of life:

☐ **Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

☐ **Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

☐ **Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.

☐ **End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to a feeling of suffocation.

If my condition is irreversible – that is, it will not improve – I direct that medically appropriate treatment be provided as indicated below. **If I mark "No" below, I authorize the withholding or withdrawal of such care:**

☐ Yes ☐ No **CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.

☐ Yes ☐ No **Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.

☐ Yes ☐ No **Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the primary illness.

☐ Yes ☐ No **Artificially Provided Nourishment and Fluids:** Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

OTHER INSTRUCTIONS

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

Other Instructions (Optional):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

CHECK THE APPROPRIATE BOXES

IF YOU WANT TO LIMIT YOUR ANATOMICAL GIFT, INDICATE THE LIMITATION HERE.

Organ Donation (Optional)

☐ Upon my death, I DO NOT wish to make an anatomical gift

☐ Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues:

_____

_____

_____

_____

SIGNATURE

Your signature must either be witnessed by two competent adults (Option A, below) or notarized (Option B, below). If witnessed, neither witness may be the person you appointed as your agent, and at least one of the witnesses must be someone who is not related to you by blood, marriage, or adoption or entitled to any part of your estate.

PRINT YOUR NAME

OPTION A: SIGN WITH WITNESSES

SIGN AND DATE YOUR ADVANCE DIRECTIVE

_____

Principal's name (please print or type)

_____

Signature of Principal
Date
(must be at least 18 or emancipated minor)

SIGNATURE OF WITNESS 1

I am a competent adult and have not been named as the Principal's agent. I witnessed the Principal's signature on this form.

_____

Signature of witness number 1 Date

SIGNATURE OF WITNESS 2

I am a competent adult and have not been named as the Principal's agent. I am not related to the Principal by blood, marriage, or adoption and I am not be entitled to any portion of the Principal's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the Principal's signature on this form.

_____

Signature of witness number 2 Date

OPTION B: SIGN BEFORE A NOTARY

PRINT YOUR NAME

_____

Principal's name (please print or type)

SIGN AND DATE YOUR ADVANCE DIRECTIVE

_____

Signature of Principal Date

STATE OF TENNESSEE

COUNTY OF _____

HAVE YOUR SIGNATURE NOTARIZED

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "Principal." The Principal personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the Principal appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

_____

Signature of Notary Public

You Have Filled Out Your Health Care Directive, Now What?

1. Your *Advance Directive* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in Google Health, or another online medical records management service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning. You can read more about Google Health at http://www.caringinfo.org/googlehealth.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Tennessee document.

7. Be aware that your Tennessee document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician if you are interested in obtaining this form. **Caring Connections does not distribute these forms.**