Advance Health Care Directive

MARYLAND

LIFE CARE planning

my values, my choices, my care

kp.org/lifecareplan

KAISER PERMANENTE®

Introduction

This advance health care directive lets you share your values, your choices, and your instructions about your future health care. This form may be used to:

- Name someone you trust to make health care choices for you (your health care agent).
- Provide written instructions about your future health care.
- Name both a health care agent AND give written instructions for future health care.

Part 1 Lets you name a health care agent.

Part 2 Gives you a chance to share what is of great value to you.

Part 3 Gives your agent written instructions about your future health care.

Part 4 Guides your agent's decision-making by stating your hopes and wishes.

Part 5 Makes your advance health care directive legally valid in the state of Maryland.

Part 6 Prepares you to share your wishes and this record with others.

People with a terminal health condition can do an oral advance directive in the presence of an attending physician or nurse practitioner and one witness.

This advance health care directive will replace any advance health care directive you have filled out in the past. In the future, if you want to cancel or change your named agent, you must sign and date a written cancellation, physically cancel or destroy your record, or direct someone to do so in your presence, orally express your wishes to cancel the document to a health care provider and witness, or execute a new advance directive. Your cancellation becomes effective when you tell your attending physician.

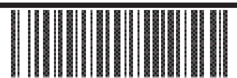
Full name: ____

Medical record number: ______________ Date of birth: ______________________

Mailing address: ____

Home phone: ____________________ Cell phone: ______________________

Work phone: ______________________ Email: ______________________



Part 1. My Health Care Agent

Choosing a health care agent: Choose someone who knows you well, whom you trust to honor your views and values, and who is able to make hard choices in stressful times.

Once you have picked your health care agent, take the time to talk about your views and care goals with that person.

If I am not able to communicate my wishes and health care decisions and my doctor and one other doctor declare in writing that I am not able to make an informed decision about health care, I choose the following person(s) to honor my wishes and make my health care decisions.

My health care agent must make health care choices that are the same as my instructions in this document and my known desires. If my agent does not know my wishes, my agent must make health care choices that he or she believes to be in my best interest, considering what he or she knows about my values.

This form does not give my health care agent the power to make financial or other business decisions.

My main health care agent is:

Full name: ______________________ Relationship to me: ______________

Home phone: ______________________ Cell phone: ______________

Work phone: ______________________ Email: ______________

Mailing address: ____

If I cancel my main health care agent's power or if my main agent is not willing or able, I name the people below as my first and second alternate agents.

First alternate health care agent:

Full name: ______________________ Relationship to me: ______________

Home phone: ______________________ Cell phone: ______________

Work phone: ______________________ Email: ______________

Mailing address: ____

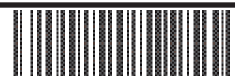
Second alternate health care agent:

Full name: ______________________ Relationship to me: ______________

Home phone: ______________________ Cell phone: ______________

Work phone: ______________________ Email: ______________

Mailing address: ____



Full name: ______________________________
Medical record number: ________________

Powers of my health care agent:

Unless I state otherwise, my health care agent has the following powers when I am not able to speak for myself or make my own choices:

A. Make choices for me about my health care. This involves decisions about tests, medicine, and surgery. It also involves decisions to provide, not provide, or stop all forms of health care to keep me alive, as well as tube feedings and IV fluids.

B. Review and release my medical records as needed to make decisions.

C. Decide which doctor, health providers, and organizations provide my health care.

D. Arrange for and make decisions about the care of my body after death (including autopsy).

Check the box below if you named your spouse or domestic partner as your agent and you want your agent to carry on with being your agent even if your marriage or domestic union ends:

❑ I want my agent to stay as my health care agent even if our marriage or domestic union is dissolved, annulled, or ended.

Please provide any added comments or limits to the previous section. (For example, you may name people you would or would not want to be involved in decisions on your behalf. You may also specify choices you would not want your agent to make.) Attach extra pages as needed.

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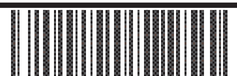
Effectiveness of this part
(Read both of these statements carefully. Then, initial one only.)

My agent's power is in effect:

_____ 1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

(or)

_____ 2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability **temporarily,** or my attending physician and a consulting doctor agree that I have lost this ability **permanently.**



Full name: ______________________________
Medical record number: ____________________

Part 2. My Values

I want my agent and loved ones to know what matters most to me, so that they can make choices about my health care that match who I am and what is of great value to me.

To give you a sense of what matters most to me, I'd like to tell you some things about myself, such as how I enjoy spending my time, whom I like to be with, and what I like to do. I'd also like to tell you about the circumstances that would make life no longer worthwhile for me.

1. If I were having a really good day, I would be doing the following:

2. What matters most to me is:

3. Life would no longer be worth living if I were not able to:

Full name: ___________________________________
Medical record number: ____________________

Part 3. My Health Care Instructions: My Choices, My Care

In the situation below, we ask you to think about a sudden unexpected event. You will always speak for yourself if you are able; in the situations below, think about what you would want if you are not able to speak for yourself.

If I become not able to communicate or make my own choices, I ask that my health care agent represent my choices as detailed below and that my doctors and health care team honor them. If my health care agent or alternate agents are not available or are not able to make choices on my behalf, this document speaks for my wishes.

Note: If you choose not to give written instructions, your health care agent will make choices based on your spoken wishes. If your wishes are unknown, your agent will make decisions based on what he or she believes is in your best interest, thinking about your values.

1. Care to prolong life

Keep in mind these situations:

You have a sudden accident or stroke.

Doctors have determined you have a brain injury, leaving you not able to recognize yourself or your loved ones. The doctors have told your agent and/or family that you are not expected to recover these abilities. Life-sustaining treatments, such as a ventilator (i.e., breathing machine) or a feeding tube are needed to keep you alive. In this condition, what would you want?

I would want to be kept comfortable and:

choose one

- ❑ I would want to STOP life-sustaining treatments. I realize this would likely lead me to die sooner than if I were to continue care that is keeping me alive.
- ❑ I would want life-sustaining treatments to continue as long as possible.

Please give any extra instructions about life-sustaining treatments. For example, you may want to state a specific time span that you would want to be kept alive if there were no change to your health.

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____
____

2. CPR (Cardiopulmonary Resuscitation)

CPR tries to bring you back to life when your heart and breathing have stopped. It may involve chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks, and a breathing tube.

You have a choice about CPR. CPR can save lives. It is not as useful as most people think. CPR works best if done quickly, within a few minutes, on a healthy adult. When CPR is performed, it can result in broken ribs, punctured lungs, or brain damage from lack of oxygen.* if you would like more information about CPR, please ask for the brochure called **CPR: My Choice.**

If your heart and breathing stop, what would you want?

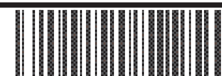
choose one

- ❑ I always want CPR attempted.
- ❑ I never want CPR attempted, but rather, want to permit a natural death.†
- ❑ I want CPR attempted unless the doctor treating me decides any of the following:
  - I have an incurable illness or injury and am dying, OR
  - I have no reasonable chance of living if my heart or breathing stops, OR
  - I have little chance of living if my heart or breathing stops and the process of CPR would cause major pain.

* Research shows that if you are in a hospital and get CPR, you have a 22% chance of it working and you leaving the hospital alive.

Ehlenbach, W., Barnato, A. E., Curtis, J. R., et al (2009). Epidemiologic study of in-hospital cardiopulmonary resuscitation in the elderly. *New England Journal of Medicine*, 361:22-31. Girotra, S., Brahmajee K., Nallamothu, M.D., et al (2012). Trends in survival after cardiac arrest. *New England Journal of Medicine*, 167:1912-20.

† If you are certain you do not want CPR, please present other documents you may want to fill out with your doctor.



Full name: ________________________________
Medical record number: ____________________

Part 4. My Hopes and Wishes (Optional)

1. My thoughts and feelings about where I would prefer to die:

____
____
____
____

2. I want my loved ones to know that if I am nearing my death, I would appreciate the following for comfort and support (prayers, rituals, music, etc.):

____
____
____
____
____

3. Religious or spiritual affiliation:

I am of the _________________________ faith, and am a member of (faith/spiritual group) ____________

______________________________ in (city) ____,

(phone number) ____. I would like my agent to tell them if I am seriously ill or dying. I would like to include in my funeral, if possible, the following (people, music, rituals, etc.):

____
____
____
____
____

4. Other wishes/instructions:

____
____
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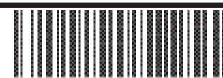
____

Organ donation

If you considered donating organs when you die, you can declare your donor status when getting or renewing a driver's license or by registering through the donor registry found at **http://www.donatelifemaryland.org/**.



Part 5. Making This Document Legally Valid

To make your advance health care directive legally valid in Maryland, it must be signed by two adult witnesses:

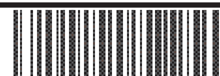
Two Witnesses

1. Witnesses cannot be your health care agent, and at least one witness cannot have the right to any financial benefit upon your death.
2. When you are with your witnesses, sign or acknowledge your signature.
3. Witnesses will sign on page 9.
4. You will sign below.

MY SIGNATURE

Print Full Name: ____

Signature: ______________________________ Date: ______________



Full name: ______________________
Medical record number: ______________

STATEMENT OF WITNESSES:

I declare under penalty of perjury under the laws of Maryland:

1. That the person who signed or acknowledged this advance health care directive is personally known to me or that the individual's identity was proven to me by convincing proof.
2. That the person signed or acknowledged this advance health care directive in my presence.
3. That the person appears to be of sound mind and under no threat, fraud, or undue influence.
4. That I am not appointed as an agent by this advance health care directive.

Witness Number One:

Print full name: ____

Address: ____

Signature: ______________________________ Date: ______________

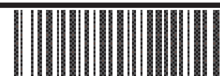
Witness Number Two:

Print full name: ____

Address: ____

Signature: ______________________________ Date: ______________

At least one witness must not be entitled to proceeds of the individual's estate or any financial benefit upon the individual's death. If you are not entitled to proceeds of the individual's estate, initial this line ______________.



Part 6. Next Steps

Now that you have filled out your advance health care directive, you should also take the following steps.

Discuss:

1. Review your health care wishes with the person you have asked to be your agent (if you haven't done so). Make sure he or she feels able to do this important job for you in the future.
2. Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care agent is and what your wishes are.

Give copies:

1. Give your health care agent a copy of your advance health care directive.
2. Give a copy of your advance health care directive to your doctor or your local Kaiser Permanente Medical Records Department.
3. Make a copy for yourself and keep it where it can be easily found.

Take with you:

1. If you go to a hospital or nursing home, take a copy of your advance health care directive and ask that it be placed in your health record.
2. Take a copy with you any time you will be away from home for a long period of time.

Review often:

1. Review your health care wishes when any of the "Five D's" occur:

   Decade – when you start each new decade of your life

   Death – when you go through the death of a loved one

   Divorce – when you go through a divorce or other major family change

   Diagnosis – when you are diagnosed with a serious health condition

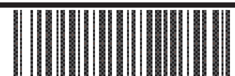
   Decline – when you feel a major drop or deterioration of an existing health condition, especially when you are not able to live on your own

Changing your advance health care directive:

If your wishes change, fill out a new advance health care directive, tell your agent and your family, and give a copy to Kaiser Permanente.

Copies of this document have been given to:

- Primary (main) health care agent — Full name:______________________ Telephone:_____________
- Alternate health care agent #1 — Full name:______________________ Telephone:_____________
- Alternate health care agent #2 — Full name:______________________ Telephone:_____________
- Health care provider/clinic — Name:_________________________ Telephone:_____________
- Others: — Name:_________________________ Telephone:_____________



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