ADVANCE DIRECTIVE FOR HEALTH CARE

(Living Will and Health Care Proxy)

This form may be used in the State of Alabama to make your wishes known about what medical treatment or other care you **would** or **would not** want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you have one and know where it is located.

I, _____, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this form and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age of my wishes and asking him or her to write them down.

I understand that these directions will only be used if I am not able to speak for myself.

If I become terminally ill or injured:

Terminally ill or injured is when my doctor and another doctor decide that I have a condition that cannot be cured and that I will likely die in the near future from this condition.

Life sustaining treatment – Life sustaining treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your initials by either "yes" or "no":

I want to have life sustaining treatment if I am terminally ill or injured.

____ Yes ____ No

Artificially provided food and hydration (Food and water through a tube or an IV) – I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initials by either "yes" or "no":

I want to have food and water provided through a tube or an IV if I am terminally ill or injured.

____ Yes ____ No

If I Become Permanently Unconscious:

Permanent unconsciousness is when my doctor and another doctor agree that within a reasonable degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

Life sustaining treatment – Life sustaining treatment includes drugs, machines, or other medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your initials by either "yes" or "no":

I want to have life-sustaining treatment if I am permanently unconscious.

____ Yes ____ No

Artificially provided food and hydration (Food and water through a tube or an IV) – I understand that if I become permanently unconscious, I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initials by either "yes" or "no":

I want to have food and water provided through a tube or an IV if I am permanently unconscious.

____ Yes ____ No

Other Directions: Please list any other things you want **done** or **not done**.

In addition to the directions I have listed on this form, I also want the following:

_____

_____

_____

_____

If you do not have other directions, place your initials here:

____ No, I do not have any other directions.

This form can be used in the State of Alabama to name a person you would like to make medical or other decisions for you if you become too sick to speak for yourself. This person is called a health care proxy. You do not have to name a health care proxy. The directions in this form will be followed even if you do not name a health care proxy.

Place your initials by only one answer:

_____ I **do not** want to name a health care proxy. *(If you check this answer, go to Section 3.)*

_____ I **do** want the person listed below to be my health care proxy. I have talked with this person about my wishes.

First choice for proxy: _____

Relationship to me: _____

Address: _____

City: _____ State _____ Zip _____

Day-time phone number: _____

Night-time phone number: _____

If this person is not able, not willing, or not available to be my health care proxy, this is my next choice:

Second choice for proxy: _____

Relationship to me: _____

Address: _____

City: _____ State _____ Zip _____

Day-time phone number: _____

Night-time phone number: _____

Instructions for Proxy

Place your initials by either "yes" or "no":

I want my health care proxy to make decisions about whether to give me food and water through a tube or an IV. ____ Yes ____ No

*Place your initials **by only one** of the following*:

_____ I want my health care proxy to follow **only** the directions as listed on this form.

_____ I want my health care proxy to follow my directions as listed on this form **and** to make any decisions about things I have not covered in the form.

_____ I want my health care proxy to make the final decision, even though it could mean doing something different from what I have listed on this form.

I understand the following:

- If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital who will follow my directions.
- If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.
- If the time comes for me to stop receiving life sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people:

  _____

  _____

Your name: _____

The month, day, and year of your birth: _____

Your signature: _____

Date signed: _____

I am witnessing this form because I believe this person to be of sound mind. I did not sign the person's signature, and I am not the health care proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least 19 years of age and am not directly responsible for paying for his or her medical care.

Name of first witness: _____

Signature: _____

Date: _____

Name of second witness: _____

Signature: _____

Date: _____

I, _____, am willing to serve as the health care proxy.

Signature: _____

Date: _____

Signature of Second Choice for Proxy:

I, _____, am willing to serve as the health care proxy if the first choice cannot serve.

Signature: _____

Date: _____

STATE BOARD OF HEALTH
ADMINISTRATIVE CODE

APPENDIX II

Alabama Portable Physician Do Not Attempt Resuscitation Order
No CPR/ Allow Natural Death

_____

Patient/Resident Full Name (PRINT) and Date of Birth:

Instructions. This order is valid only if Section I, II, III, OR IV is completed AND a physician has completed Section V.

Section I. Patient/Resident Consent.

I, the undersigned patient/resident, direct that resuscitative measures be withheld from me in the event of cardiopulmonary cessation. I have discussed this decision with my physician, and I understand the consequences of this decision.

_____ _____
Signature of Patient/Resident Date

Section II. Incompetent Patient/Resident with DNAR instructions in Advance Directive.

The patient/resident is not competent or is no longer able to understand, appreciate, and direct his/her medical treatment and has no hope of regaining that ability. A duly executed Advance Directive for Health Care with instructions that no life sustaining treatment be provided was previously authorized by the patient/resident and is part of his/her medical record.

_____
Signature of provider or facility representative

_____ _____
Print name Date

Section III. Health Care Proxy or Attorney-in-Fact Consent.

I, the undersigned, am the health care proxy or attorney-in-fact designated by the patient/resident to make decisions regarding the providing, withholding, or withdrawal of life-sustaining treatment for the patient/resident. I hereby direct that resuscitative measures be withheld from the patient/resident in the event of cardiopulmonary cessation. A copy of the proxy or attorney-in-fact designation (e.g., living will, power of attorney, etc.) has been made part of the patient/resident's medical record.

_____
Signature of Proxy or Attorney-in-Fact

_____ _____
Print name Date

Section IV. Surrogate Consent.

I, the undersigned, am the surrogate certified to make decisions, in consultation with the attending physician, regarding the providing, withholding, or withdrawal of life-sustaining treatment for the patient/resident. After consultation with the attending physician, I hereby direct that resuscitative measures be withheld from the patient/resident in the event of cardiopulmonary cessation. I believe that this decision conforms as closely as possible to what the patient/resident would have wanted. I make this decision in good faith and without consideration of the financial benefit or burden which may accrue to me or to the health care provider as a result of this decision. A copy of the Certification of Health Care Decision Surrogate has been made part of the patient/resident's medical record.

_____
Signature of Surrogate

_____ _____
Print name Date

Section V. Physician Authorization.

Based on the information above, I hereby direct any and all medical personnel, emergency responders, and paramedical personnel to withhold resuscitative measures, i.e., cardiopulmonary resuscitation, chest compression, endotracheal intubation and other advanced airway management, artificial ventilation, cardiac resuscitative medications, and cardiac defibrillation, in the event of cardiopulmonary cessation in the patient/resident.

I further direct the implementation of all reasonable comfort care such as oxygen, suction, control of bleeding, administration of pain medication by personnel so authorized, and other therapies to provide comfort and alleviate suffering by the patient/resident; and to provide support to the patient, family members, friends, and others present.

_____
Signature of Physician

_____ _____
Print name Date

ATTACHMENT B

CERTIFICATE OF HEALTH CARE DECISION SURROGATE

PATIENT'S NAME:_____
SURROGATE'S NAME:_____

I certify that:

(a) I am at least nineteen years old.

(b) The patient whose name is given above either has not, to my knowledge, made an advance directive for health care (living will or durable power of attorney), or the patient has executed an advance directive for health care, but the document fails to address his or her present circumstances.

(c) I have consulted with the physician who is now overseeing the patient's care.

(d) I am qualified to act as a surrogate health care decision maker for this patient because:

I. My relationship to the patient is the one indicated by checkmark below.

II. I have spoken to or attempted to speak to all other adults, if there are any, who fit into my category, and to all those who fit into a higher category (on the list below, a higher category is one listed before my category). Each such person that I spoke to has either agreed that I may act as surrogate, or has expressed no objection to my acting as surrogate.

III. If I have not spoken to any such person, it is because the person is in an unknown location, or because he or she is in a location so remote that he or she cannot, as a practical matter, be contacted in a timely fashion, or because he or she has been adjudged incompetent and remains incompetent today.

____ 1. I am the judicially-appointed guardian of the patient. My guardianship appointment specifically gives me the authority to make health care decisions for the patient.

____ 2. I am the husband or wife of the patient.

____ 3. I am a child of the patient.

____ 4. I am a parent of the patient.

____ 5. I am a brother or sister of the patient.

____ 6. I am another person related to the patient by blood. To my knowledge, the patient has no living relatives, or the patient's closer living relatives either cannot or will not serve as surrogates. I am the patient's _____.

____ 7. The patient has no known relatives who are able and willing to act as surrogate. I am a representative of the ethics committee at the facility where the patient is being treated or I am a representative of some other committee duly appointed to make health care decisions for this patient.

(e) I understand that under the laws of Alabama certification on this form of any information known by me to be false is a Class C felony, which has a penalty of up to ten years imprisonment, and a fine of up to $5,000.

_____
Signature of Surrogate

Sworn to (or affirmed) and subscribed before me this ____ day of _____, ___.

_____
Notary Public