Doylestown Health

Your Guide to Healthcare Decisions

Advance healthcare directives are written plans you make about your choices for medical care and related wishes. These plans let your healthcare providers, family members or other important people in your life know the choices you have made.

Why do I need an advance healthcare directive? Writing your advance directive lets you control your healthcare decisions at a time when you are not able to communicate and make your wishes known. It protects your right to accept or refuse any care provided to you. Doylestown Hospital will follow your advance directive except in some rare circumstances involving pregnancy or futility of care.

When does my advance directive take effect? In general, your advance directive will take effect only at the time when you are not able to make healthcare decisions for yourself.

How do I make **an advance healthcare directive?** To be sure your choices are clearly understood, it is best to have a written directive. It should be signed by you, dated, and signed by two witnesses.

In Pennsylvania, there are two kinds of advance healthcare directives:

1. Living will
2. Healthcare power of attorney

What is a living will? A living will is a written record of the healthcare wishes you choose for yourself. Your choices will be put into place by your healthcare providers only when you are no longer able to make decisions for yourself and are either permanently unconscious or have an end stage medical condition.

What is a healthcare power of attorney? A healthcare power of attorney is a legal written document that names a person (agent) to act on your behalf. It allows your agent to make health care choices for you, and will only take effect when you are not able to make those choices for yourself.

Who should have a copy of my forms? You should give a copy to your primary care doctor, hospital, long term care provider, healthcare agent, lawyer, and any loved ones who need to know your wishes.

** **You may change your advance healthcare directive AT ANY TIME**. It is a good idea to review your advance health care directive every year and make changes if needed.

Advance healthcare directive forms and more information can be found on the Doylestown Health website DoylestownHealth.org

Advance healthcare directive forms are also available from community programs and internet search engines.

Advance Healthcare Directive

For_____ Date of birth_____

I, _____ , of _____ County, Pennsylvania, make this Advance Healthcare Directive of my own free will. I ask that my family, loved ones, and caregivers honor my wishes which are intended to lessen any burden placed on them and minimize a any feelings of guilt.

My Healthcare Choices

If I ever lose my ability to communicate my wishes, my healthcare agent shall make decisions consistent with my stated desires and values and is subject to any special instructions or limitations that I may list here. I want my healthcare agent to make decisions that, in his or her best judgment, would best achieve the acceptable quality of life I have outlined below.

To me an acceptable quality of life is when I can:

If I reach a point where doctors are reasonably certain that I will never regain an acceptable quality of life as outlined above, I want to stop or withdraw all care and treatment that would only prolong my life; I want to receive care and treatment that will make me comfortable. The following are important to me for comfort: *(If you don't write specific wishes, your physician and nurses will provide the best standard of care possible.)*

Print name: _____

Please initial the following if you agree:

_____ I consent to donate any organs or tissue if I am a candidate.

Other instructions I want my healthcare agent to follow based on my moral, religious, or ethical considerations:

My Healthcare Agent

I elect to name a healthcare agent if I am no longer able to make my own healthcare decisions.

Name of agent: _____ Relationship: _____

If my agent is unable to serve for any reason, then my alternate choice is:

First alternate agent:_____ Relationship: _____

If my alternate agent is unable to serve for any reason then my choice for healthcare agent is:

Second alternate agent:_____ Relationship: _____

For current contact information, see attached page.

Please note:

_____ My healthcare agent must follow my healthcare choices

OR

_____ My healthcare choices are only guidance. My healthcare agent shall have final say and may override any of my choices.

Print name: _____

Healthcare Agent's Powers

I want my healthcare agent to be able to do the following:

- To authorize, withhold, or withdraw medical care and surgical procedures, including a Do Not Rescuscitate order.

- To authorize, withhold, or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries, or veins.

- To authorize my admission to or discharge from a medical, nursing, residential, or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.

Effective immediately, I authorize all healthcare providers and insurers to disclose to my healthcare agent (personal representative), upon my healthcare agent's request, any information, including medical records, regarding my physical or mental health which may be private and protected by law.

Having carefully read this document, I have signed it on this day of _____, 20 _____, revoking all previous healthcare directives, healthcare powers of attorney, living wills, and medical healthcare treatment instructions.

Signature (Principal)_____

Witness _____ Address_____

Witness _____ Address_____

Notarization (optional)

On this _____ day of _____ , 20 _____ , before me personally appeared the aforesaid declarant and principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of Bucks, State of Pennsylvania, the day and year first above written.

Notary_____Print name: _____

Current Healthcare Agent Contact Information

For_____ as of _____ , 20 _____

Healthcare agent appointed in my Advance Directive:

Name:_____Relationship:_____

Address:_____

Home Phone: _____Cell Phone: _____

Email: _____

First alternative healthcare agent appointed in my Advance Directive:

Name:_____Relationship:_____

Address:_____

Home Phone: _____Cell Phone: _____

Email: _____

Second alternative healthcare agent appointed in my Advance Directive:

Name:_____Relationship:_____

Address:_____

Home Phone: _____Cell Phone: _____

Email: _____

Print name: _____