CHI St. Francis Health

Healthcare Directive

Purpose of form

Part 1 Allows you to appoint another person (called an agent) to make healthcare decisions if a doctor decides you are unable to do so.
Part 2 Allows you to give written instructions about what you want.
Part 3 Requires you and others to sign and date to make this legal.

My Personal Information

Name: _____
Address: _____
_____
Home Phone _____ **Work Phone** _____
Date of Birth _____ **Social Security Number** _____

I evoke all living wills, durable powers of attorney for health care, or other written advance healthcare directives I have signed in the past.

Part 1: Naming an Agent

Agent Duties

My healthcare agent can:

- Make health care decisions for me if I am unable to make and communicate decisions for myself.
- Make decisions based on any information in part 2 of this document, or in other documents.
- Make decisions based on what he or she knows about my wishes.
- Act in my best interests if instructions are not available.

Agent Roles

When naming your healthcare agent, choose one of the following. Initial the line in front of the statement you want.

Act Alone

_____ I appoint one person to serve as my primary healthcare agent to make decisions for me if I am unable to make or communicate these decisions for myself. My primary agent may act alone. If my primary agent is not able, willing, or available, each alternate agent I name may act alone, in the order listed.

Act Together

_____ I appoint two or more persons to act together as my healthcare agent. My primary agent and alternate agent must act together and be in agreement when making decisions. IF they are not all readily available, or if they disagree, a majority of the agents who are readily available may make decisions for me.

My Primary Healthcare Agent

I appoint:

Agent's Name: _____
Address: _____
_____

Home Phone: _____ **Work Phone**: _____

My First Alternate Healthcare Agent

Agent's Name: _____
Address: _____
_____
Home Phone: _____ **Work Phone**: _____

My Second Alternate Healthcare Agent

Agent's Name: _____
Address: _____
_____
Home Phone: _____ **Work Phone**: _____

Reasons for naming healthcare provider (if applicable)

I have named as my agent a healthcare provider , or employee of a healthcare provider, who is currently or might be providing direct care to me when decisions are needed. That person is not related to me b blood, marriage, registered domestic partnership, or adoption. My reasons for wanting to appoint that person as my agent are:

_____

_____

_____

Powers of My Agent

If I am unable to decide or speak for myself, my agent has the power to:

- Consent to, refuse, or withdraw any health care treatment, service, or procedure.
- Stop or not start health care that is keeping or might keep me alive.
- Choose my healthcare providers.
- Choose where I live when I need health care and what personal security measures are needed to keep me safe.
- Obtain copies of my medical records and allow others to see them.

Additional Powers of My Agent

If I want my agent to have any of the following powers, I must initial the line in front of the statement.

I also authorize my agent to:

_____ Make healthcare decisions for me even if I am unable to decide or speak for myself.

_____ Carry out my wishes regarding a funder or burial or what will happen to my body if I die.

_____Make decisions about mental health treatment, including electroconvulsive therapy and antipsychotic medication, including neuroleptics.
_____ In the event that I am pregnant, determine whether to attempt to continue my pregnancy to deliver based upon my agent's understanding of my values, preferences, or instructions.
_____ Continue as my healthcare agent even if a dissolution, annulment, or termination of our marriage or domestic partnership is in process or has been completed.

Limiting the Powers of My Agent

I wish to limit the powers of my healthcare agent in the following way(s):
_____

_____

_____

_____

Part 2: Healthcare Instructions

- I give the following instructions about my health care (my values and beliefs, what I do and do not want, and my views about medical treatments or situations):
  _____

  _____

  _____

  _____

- I am attaching additional instructions about my health care (my values and beliefs, what I do and do not want, and my views about medical treatments or situations). Initial one line.
  _____ Yes _____ No

- I authorize donation of organs, tissue, or other body parts after my death.
  _____ Yes _____ No

Part 3: Making this Document Legal

My Signature/Mark and Date

I agree with everything in this document and have made this document willingly:

Signature: _____

Date: _____ (day/month/year)

Notary Public or Witnesses:

Notary Public or Witnesses (Note:Notary Public must not be named as agent or alternate agent.)

State of _____ County of _____

This document was signed or acknowledged before me this ____ (day) of _____ (month), _____ (year), by the above named principal.

Signature of Notary Public; _____

Two Witnesses (Note: Only one witness can be a direct care provider or employee of a provider on the day this is signed.)

Witness Signature: _____
Address _____
Date _____ (day/month/year)

Witness Signature: _____
Address _____
Date _____ (day/month/year)

Acceptance of Appointment of Power of Attorney

I accept this appointment and agree to serve as agent for health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment. I understand that this document gives me authority over healthcare decisions for the principal only if the principal becomes incapacitated. I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal make revoke this power of attorney at any time in any manner.

If I choose to withdraw, during the time the principal is competent, I must notify the principal of my decision. If I choose to withdraw when the principal is not able to make healthcare decisions, I must notify the principal's physician>

Signature of Agent/Date: _____

Signature of Alternate Agent/Date: _____