

Vermont Advance Directive for Health Care

MY NAME _____ DATE OF BIRTH _____ SS # _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
TELEPHONE (DAY) _____ (EVENING) _____
CELL PHONE _____ EMAIL _____

PART ONE: APPOINTMENT OF MY HEALTH CARE AGENT

I want my agent to make decisions for me:

- _____ when I am no longer able to make health care decisions for myself;
- _____ when the following conditions or events occur (please specify) _____
_____;
- _____ immediately upon signing, allowing my agent to act for me now.

I APPOINT _____ as my Health Care **Agent** to make any and all health care decisions for me. This shall take effect in the event I become unable to make my own health care decisions or as otherwise indicated in this document.

ADDRESS _____
TELEPHONE (DAY) _____ (EVENING) _____
CELL PHONE _____ EMAIL _____

Agent's acceptance (Agent's signature *not* required by law)

The responsibilities and role of an agent have been discussed with me and I agree to accept them.

Signature *Date*

If this health care agent is unavailable, unwilling, or unable to do this for me, I appoint _____ to be my **Alternate Agent**.

ADDRESS _____
TELEPHONE (DAY) _____ (EVENING) _____
CELL PHONE _____ EMAIL _____

Alternate Agent's Acceptance (Alternate Agent's signature *not* required by law)

The responsibilities and role of an alternate agent have been discussed with me and I agree to accept them. _____

Signature

Date

Others who can be consulted about medical decisions on my behalf include:

Those who should **not** be consulted include:

The space below is to identify your doctor or health care provider. *Note: your doctor cannot also serve as your health care agent.*

Primary Care Physician _____

ADDRESS _____

TELEPHONE _____

Other Health Care Professional _____

ADDRESS _____

TELEPHONE _____

Notification

If I am unable to do so myself, I request that facility staff or my agent notify the following individuals immediately that I have been admitted to a health care facility.

Name _____ Relationship _____

ADDRESS _____

TELEPHONE _____

Name _____ Relationship _____

ADDRESS _____

TELEPHONE _____

PART TWO: TREATMENT WISHES – SECTION ONE

Please express your preferences by initialing the statements you agree with. **You may initial more than one choice.** Draw a line through any statement you do not agree with. If you do nothing, your agent or others such as family members and doctors treating you will assume you want them to decide for you. **If you do not state a preference for withholding or withdrawing artificial food (tube feeding) and hydration, your agent may not have authorization to withhold or withdraw it, without a court order, if you are being treated in a New York or New Hampshire hospital.**

____ **A. My choice is to limit physical health care treatment as follows:**

- ____ 1. I do not want to be kept alive if I am so sick that I will die within a relatively short time (I cannot get better and have only weeks, days, or hours left to live).
- ____ 2. I do not want to be kept alive if I become unconscious or unaware of my surroundings and most doctors agree that I will never regain consciousness.
- ____ 3. I do not want to be kept alive if I become unable to think or act for myself (and won't get better.)
- ____ 4. I do not want to be kept alive if the likely risks and burdens of treatment would outweigh the expected benefits. (For example: I will be in pain, or I will be unable to do things for myself, or the costs of caring for me will be beyond my willingness to pay.)
- ____ 5. If it is possible that I might recover with treatment and **more time is needed** to determine if I can get better or not, I wish my medical team to start the necessary treatments to keep me alive. If, over time, these treatments do not improve my chances of living or my physical condition, I wish to have life-sustaining treatment stopped.
- ____ 6. If any of the situations I have initialed above occur, and if I am also unable to swallow enough food and water to stay alive, I **do** want food and water to be given to me by vein or feeding tube.
- ____ 7. If any of the situations I have initialed above occur, and if I am also unable to swallow enough food and water to stay alive, I **do not** want food and water to be given to me by vein or feeding tube; however, I will accept medication for pain and agitation via an IV line.
- ____ 8. If I am pregnant at the time my Advance Directive becomes effective I make the following changes to my treatment wishes expressed above

____ **B. My Choice is to Sustain Life.** I want to be kept alive as long as possible through any means possible regardless of my condition or awareness.

OTHER SPECIFIC INSTRUCTIONS ARE AS FOLLOWS:

HOME/COMMUNITY CARE/RESPITE CENTER

I prefer the following home or community-based services/facilities as an alternative to psychiatric hospitalization: _____

HOSPITAL OR OTHER TREATMENT FACILITIES

If I need hospitalization or care in a treatment facility, the following facilities are listed *in order of preference*:

Name _____ Telephone _____

I prefer this facility because (optional) _____

Name _____ Telephone _____

I prefer this facility because (optional) _____

Name _____ Telephone _____

I prefer this facility because (optional) _____

AVOID USING THE FOLLOWING HOSPITALS OR TREATMENT FACILITIES:

Name and reason to avoid (optional) _____

Name and reason to avoid (optional) _____

HELP FROM OTHERS

Please do the following things that help reduce my symptoms, make me more comfortable, and keep me safe: _____

Do not do the following, they will not help and may even make matters worse: _____

I **do not** want the following people to visit me while I am in a health care facility.

Name and reason (optional) _____

Name and reason (optional) _____

MEDICATION

Pharmacy Name _____ Telephone _____

Allergies _____

MEDICATION PREFERENCES

I have the following preferences for medications & health care preparations: _____

Use the following medications and health care preparations *only* if all other options have been ruled out as being ineffective by my treating physician: _____

MEDICATIONS AND HEALTH CARE PREPARATIONS TO AVOID AND WHY

I **do not** consent and I **do not** authorize my agent to consent to the administration of the following medications: _____

STATEMENT OF INFORMED CONSENT (*Initial if you agree*)

I am aware that the medication decisions I state in this document may result in longer hospital stays and may also result in an Application for Involuntary Treatment being filed or in a continuation of my being involuntarily committed or treated. I have made my treatment decisions with full awareness of these and other possible consequences. _____

EMERGENCY INVOLUNTARY TREATMENT

If it is determined that an emergency involuntary treatment must be provided for me, I prefer these interventions in the following order: (List by number as many as you choose. For example, 1 = first choice; 2 = second choice, etc. You may also note the type of medication and maximum):

- _____ Liquid medication
- _____ Medication by injection
- _____ Medication in pill form
- _____ Physical restraints
- _____ Seclusion
- _____ Seclusion and physical restraints combined
- _____ Other _____

Reason for preferences (optional) _____

ELECTROCONVULSIVE THERAPY (ECT or Shock Treatment)

If it is determined that I am not legally capable of consenting to or refusing ECT my preference is initialed below:

_____ I **DO NOT** consent to the administration of ECT.

_____ I **consent** and authorize my agent to consent to the administration of ECT as follows:

_____ I **consent / do not consent** (circle one) to unilateral ECT

_____ I **consent / do not consent** (circle one) to bifrontal ECT

_____ I **consent / do not consent** (circle one) to bilateral ECT

_____ I **agree** to the number of treatments that the attending psychiatrist deems appropriate.

_____ I **agree** to the number of treatments that Dr. _____ deems appropriate.

_____ I **agree** to the number of treatments that my Agent deems appropriate.

_____ I **agree** to no more that the following number of treatments. _____

Other instructions regarding the administration of ECT: _____

CONSENT FOR STUDENT, TREATMENT STUDIES OR DRUG TRIALS (Initial your choice)

_____ I **consent /do not consent** to my participation in student education, treatment studies, or drug trials.

_____ I authorize my agent to consent to my participation in student education, treatment studies, or drug trials after consulting with my physician and any other individuals my agent thinks appropriate, determines that the benefits to me outweigh the risks, and that other, non-experimental interventions are not likely to provide effective treatment.

GUARDIANSHIP

If the court appoints a guardian for me, I request that the following person be appointed:

Name _____ Relationship _____

ADDRESS _____

TELEPHONE _____

I do *not* wish the following person(s) to be considered as potential guardian(s) for me:

RELEASE OF MEDICAL INFORMATION

If I am ever involuntarily admitted to a health care facility, I give **permission** to that facility and its staff to disclose all information in my medical record (including personal observations) to the agent and alternate agent appointed in my Advance Directive. This release is to take effect regardless of my capacity. I also give permission for my agent to authorize release of my health care information to the following individual(s): _____

This release is intended to include records regarding psychiatric treatment and drug and alcohol treatment. (Initial if you agree) _____

CARE OF CHILDREN, PETS OR OTHER DEPENDENTS

In the event that I am unable to care for my child(ren), pets, or other dependants, the following is my first choice to provide care:

Name _____ Relationship _____

ADDRESS _____

TELEPHONE _____

ENFORCEMENT PROVISION

I grant my agent, my alternate agent, and Disability Rights Vermont the authority to enforce compliance with and implementation of my Advance Directive for health care. I further grant them the authority to request an evaluation to determine my ability to make my own health care decisions. *(Initial if you agree)*

PART TWO: TREATMENT WISHES – SECTION TWO

Waiver of Right to Request or Object to Treatment

Section Two is a special part that may be used by people who want their future responses to offered health treatment disregarded or ignored. **You must have an agent to fill out this Section.**

There may be situations in which you might be objecting to or requesting treatment but would then want your objections or requests *to be disregarded*. If you have had treatment in the past that scares you or is uncomfortable or painful you may be likely to say “no” when it is offered in a future health crisis. Still, you may know that this is the only way for you to come through a bad time or even survive. You understand that it is necessary and you would want it again if you had to have it. This Section will help you let your agent and others know what you *really* want for yourself.

Because this is signing away a basic right that all patients have (to refuse or to request treatment) unless a court orders otherwise, you will need to give this much careful thought. You will also have to have additional signature(s) and assurances at the time you fill out this Section of your Advance Directive.

If you think Part Two Section Two could apply to you and be helpful in your situation, you need to be sure that everyone involved in your care understands that you are making this choice of your own free will and that you understand the ramifications of waiving your right either to consent or to object to treatment.

Unlike other Parts of your Advance Directive, you can revoke this section ***only when you have capacity to make medical decisions*** as determined by your doctor and another clinician.

For your agent to be able to make healthcare decisions over your objection, you must:

- Name your agent who is entitled to make decisions over your objection;
- Specify what treatments you are allowing your agent to consent to or to refuse over your objection;
- State that you either do or do not desire the specified treatment even over your objection at the time;
- Acknowledge in writing that you are knowingly and voluntarily waiving the right to refuse or receive specified treatment at a time of incapacity;
- Have your agent agree in writing to accept the responsibility to act over your objection;
- Have your clinician affirm in writing that you appeared to understand the benefits, risks, and alternatives to the proposed health care being authorized or rejected by you in this provision; and
- Have an **ombudsman, recognized member of the clergy, attorney licensed to practice in Vermont, or a probate court designee** affirm in writing that he or she has explained the nature and effect of this provision to you and that you appeared to understand this explanation and be free from duress or undue influence.

I hereby give my agent _____ the authority to consent to or refuse the following treatment(s) over my objection if I am determined by two clinicians to lack capacity to make healthcare decisions at the time such treatment is considered:

I do want the following treatment to be provided, even over my objection, at the time the treatment is offered: _____

I do not want the following treatment, *even over my request* for that treatment, at the time the treatment is offered: _____

I give my permission for my agent to agree to have me admitted to a designated hospital or treatment facility even over my objection.

_____ Yes _____ No

I give my agent permission to agree that my release from a voluntary admission for mental health treatment may be delayed even over my objection for up to four days so that a decision can be made regarding whether I meet criteria to be involuntary committed.

_____ Yes _____ No

I hereby affirm that I am knowingly and voluntarily waiving the right to refuse or receive treatment at a time of incapacity, and that I understand that my doctor and one other clinician will determine whether or not I have capacity to make health care decisions at that time. I know that I can revoke this part of my Advance Directive only when I have the capacity to do so, as determined by my doctor and at least one other clinician.

Signature

Date

(A) I, as the designated agent for this Advance Directive, hereby accept the responsibility of authorizing or withholding health care over the principal's objection in the event that the principal lacks capacity to make healthcare decisions.

Signature Agent

Signature Alternate Agent

Agent (Print Name)

Alternate Agent (Print Name)

(B) I, as clinician for the principal, affirm that the principal appeared to understand the benefits, risks, and alternatives to the health care being authorized or rejected by the principal in this provision.

Signature Clinician

Clinician (Print Name and Title)

(C) I am an ombudsman, recognized member of the clergy, attorney licensed in Vermont, or a probate court designee (Please circle the appropriate designation) and hereby affirm that I have explained the nature and effect of the provision to the principal, and that the principal appeared to understand the explanation and be free from duress or undue influence.

Signature

(Print Name and Title)

Specific Wishes Near the End of My Life

You may wish to direct how you are to be treated when it is clear your death is unavoidable and near. Below are some options you may choose. Please initial the choice(s) that express your desire for end of life treatment.

____ If it becomes clear to my doctor, agent, and those caring for me that I am dying I want palliative care for my pain, worries, nausea, and other conditions that bother me. I want sufficient **pain medication** to make me comfortable even though such medication may hasten my death.

____ I want **hospice care** when I am dying, if possible and appropriate.

____ I want to die **at home** if this is possible.

____ Other preferences _____

Spiritual and Other Care Concerns

I am of the _____ faith. Below is the contact information (if known).

Church, synagogue, or worship center: _____

Leader _____

ADDRESS _____

TELEPHONE _____

The following music, readings, or art would be a comfort to me and I request that my agent or those caring for me at that time attempt to provide me with them: _____

PART THREE: SPECIFIC INSTRUCTIONS ABOUT ORGAN DONATION

Vermont law allows you to specify whether you want some or all of your organs to be donated for use by other patients or for research or educational purposes. This is an important decision that you should discuss with your family, friends and medical providers.

(Initial all that apply.)

___ I wish to donate the following organs and tissues for use by other patients:

- ___ any needed organs
- ___ major organs (heart, lungs, kidneys, etc.)
- ___ tissues such as skin or bones
- ___ eye tissue such as corneas

___ I give my agent authority to make organ donation decisions for me. (Note: in order for this section to be effective your agent may not be a cemetery or funeral home employee unless he/she is related to you by blood, marriage, civil union or adoption.)

___ I wish to donate my body to research or educational programs. (Note: you will have to make your own arrangements through a medical school or other program.)

___ If an **autopsy** is suggested for any reason, I give my permission to have it done.

PART FOUR: MY WISHES FOR DISPOSITION OF MY REMAINS FOLLOWING MY DEATH

Vermont law allows you to make decisions about the disposition of your body in case of your death. Below you may indicate who you wish to be responsible for the disposition of your body, how and where you would like your body laid to rest, and the names of any funeral homes, cemeteries or other entities that you want to be notified of your death. _____

___ I give my agent authority to make disposition decisions following my death . (Note: in order for this section to be effective your agent may not be a cemetery or funeral home employee unless he/she is related to you by blood, marriage, civil union or adoption)

PART FIVE: SIGNED DECLARATION OF WISHES

I declare that this document reflects my desires regarding my future health care and end of life decisions and that I am signing this Advance Directive voluntarily and of my own free will.

Signature *Date*

The witnesses below affirm that the Principal appears to understand the nature of an Advance Directive and is signing this document voluntarily without duress or undue influence. Appointed agents, family members and heirs may not be witnesses. *(Please sign and print.)*

First Witness _____
Print Name: _____
Address _____

Second Witness _____
Print Name: _____
Address _____

If the Principal is in the process of admission to or is currently a patient or resident of a hospital, nursing home, or residential care home, the following *additional witness* (for example: a hospital explainer, long term care ombudsman or clergy, attorney, probate court designee) affirms that he/she has explained the nature and effect of the Advance Directive to the Principal and affirms that the Principal appears to be signing this document voluntarily without duress or undue influence.

Signature _____
Name _____ Title / Position _____
Address _____ Date _____

If you may receive care in the State of New York or New Hampshire this document must be notarized.

On _____ at _____ in the county of _____ State of Vermont, _____ did personally appear before me and did swear that the above information was true to the best of her/his belief and that no form of coercion, force or threat was involved in the decision to sign the instant document.

Signed _____, Notary Public
My commission expires on _____

IMPORTANT!

Please check below the people and locations that will have a copy of this document:

Remember that if you amend, suspend or revoke this document at any time, it is your responsibility to notify the individuals and entities that have been provided copies of this document about any change to it.

____ Health care agent

____ Alternate health care agent

____ Disability Rights Vermont: 141 Main St., Suite 7 Montpelier, VT 05602 1-800-834-7890

____ Family members (name and address of all who have copies)

 Name _____

 Address _____

 Name _____

 Address _____

____ Physicians (name and address of all who have copies)

 Name _____

 Address _____

 Name _____

 Address _____

____ Hospital(s)

 Name _____

 Name _____

 Name _____

____ Other

 Name _____

 Address _____

____ Vermont Advance Directive Registry (P.O. Box 2789, Westfield, NJ 07091-2789)

Please send a copy of your Advance Directive along with a completed Registration Agreement form that may be obtained from the Vermont Department of Health. For additional information see the State of Vermont Department of Health website: <http://www.healthvermont.gov/vadr/> or call the Vermont Department of Health at 1-800-548-9455.

The original of this document will be kept at _____

Disability Rights Vermont
141 Main Street Suite 7
Montpelier, Vermont 05602
1-800-834-7890 or 802-229-1355
802-229-2603 TTY
www.disabilityrightsvt.org
info@disabilityrightsvt.org (email)

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