# ALL CARE MEDICAL CONSULTANTS P.A.

## Acknowledgement for Advanced Directives

*Introduction:* As a part of a person's right to self-determination, every adult may accept or refuse any recommended medical treatment. This is relatively easy when people are well and can speak. Unfortunately, during severe illness people are often unconscious or otherwise unable to communicate their wishes at the time when many critical decisions need to be made.

During the time, important decisions about your medical care may have to be made. Without any written instructions from you, your family and physicians would have to guess what treatment you would want. In some cases, they may be forced to proceed with treatments they know you would not desire simply because your preference was not expressed in writing. You can help your family and physicians by telling them, in advance, what you would want done in certain situations. This planning ahead for future healthcare decisions is known as an Advance Directive.

The Advanced Directives states your wishes regarding various types of medical treatment in several representative situations so that your desires can be respected. It comes into effect only if you become incompetent (unable to make decisions or express your wishes), and you can change it at any time until then. As long as you are competent, you should discuss your care directly with your physician. Before you fill out the Advanced Directive-Living Will, Healthcare Surrogate/or DNR form, you may want to talk to your family, friends, physician, lawyer or spiritual advisor. The Advanced Directives also lets you appoint someone to make medical decisions for you, if you should become unable to make your own; this is a proxy or durable power or attorney. Additionally, it contains a statement of your wishes concerning organ donation.

When you make your personal choices in the Directive, you may want to consider one question. Is there a condition or set of circumstances which could exist in which you would refuse efforts to prolong your life? The Directive describes situations and allows you to indicate which treatments you would or would not want if your physician recommended them. If a situation you are particularly concerned about is not included; you can make additional comments in the section provided.

As your Medical-Doctor, we need to know if you have executed an Advanced Medical Directive:

Yes_____ or No _____

If yes, this Directive is in the form of:

_____ A Living Will
_____ A Durable Power of Attorney
_____ A Health Care Surrogate
_____ An Executor/Minister of your Estate

If you have executed an Advanced Directive in any of the above format and have not yet provided our office with a copy, could you please do so at your next visit.

_____ _____

Patient Signature Date

# Designation of Health Care Surrogate

Name: _____
(Last) (First) (MI)

In the event that I have been determined by my physician to be incompetent/incapacitated (lack of ability) to provide informed consent for medical treatment and surgical and diagnostic procedures including, but not limited to, the withholding, withdrawal, or continuation of life – prolonging procedures, I wish to designate as my decision maker (surrogate) to make health care decisions.

Name: _____/ _____
(Relationship)

Address: _____

Phone: _____

If my surrogate is unwilling or unable to perform his/her duties, I wish to designate as my alternate surrogate:

Name: _____/ _____
(Relationship)

Address: _____

Phone: _____

I fully understand that this designation will permit my decision maker to make all health care decisions on my behalf until I regain the ability to make healthcare decisions. The health care may also include if necessary the decisions to withhold, withdraw, or continue life prolonging procedures. My decision maker may also authorize my admission to or transfer from a health care facility and also apply for public assistance on my behalf. This designation is to remain in effect during any incapacity or incompetency I may experience.

**Nutrition and Hydration**

I do ( ) I do not ( ) desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to artificially prolong the process of dying.

Additional instructions (optional):

_____

_____

_____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they know who my surrogate is.

Name: _____

Name: _____

Name: _____

Patient Signature: _____ Date: _____

Witnesses (required): 1. _____

2. _____

(At least one witness must be neither a spouse nor blood relative of the signatory)

# Living Will

Declaration made this _____ day of _____, 20_____

I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____ (initial) I have a terminal condition, or

_____ (initial) I have an end-state condition, or

_____ (initial) I am in a persistent vegetative state

and if my attending or treating physician and another consulting physician have determined that there is no reasonable probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the applications of such procedures would service only to artificially prolong the process of dying, and that I be permitted to die naturally with only the administration of medicine or the performance of any medical procedure deemed necessarily to provide me with comfort care or to alleviate pain.

It is my intension that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate the provisions of this declaration.

Name: _____/ _____
(Relationship)

Address: _____

Phone: _____

I understand the full importance of this declaration, and I am emotionally and mentally competent to make this declaration.

**Nutrition and Hydration**

I do ( ) I do not ( ) desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to artificially prolong the process of dying.

I do ( ) I do not ( ) desire to donate my organs.

Additional Instructions (optional):

_____

_____

_____
(Patient Signature)

_____ _____
(Witness) (Witness)

Address: _____8900 Park Blvd_____ Address: _____8900 Park Blvd_____

_____Seminole, FL 33777_____ _____Seminole, FL 33777_____

Phone: _____727-545-4545_____ Phone: 727-545-4545_____

(At least one witness must be neither a spouse nor blood relative of the signatory.)