ADVANCE DIRECTIVE FOR HEALTH CARE (DETAILED)

FOR: _____

(PATIENT'S NAME)

In order to assist my Health Care Representative in making health care decisions for me as easily and confidently as possible, I leave these specific instructions to supplement my Advance Directive for Health Care and Health Care Representative appointment, or any other document appointing a Health Care Representative, or other document stating my wishes, or any individual whom I have selected who is serving as my Health Care Representative, or by law if no one is appointed by me, or my Health Care Representative authorized or as granted by a court of Law. Any decisions stated herein will supersede any previously dated document that conflicts with my wishes and decisions stated in this document.

Instructions for Healthcare Providers/Decision Makers

I have carefully selected individual(s) I wish to make medical decisions for me in the event of my incapacity. It is my firm belief that these individuals are the best positioned to make such decisions on my behalf. I consider my health care a personal and private matter. I do not wish to have other individuals or organizations involved in my health care decision-making unless specified in these instructions.

If I have named a Health Care Representative(s) in a previous directive, the intent of naming my Representative was to send a clear signal to my health care providers regarding my wishes and to avoid conflict among my family and other persons concerned with my healthcare. I do not wish the appointment of my Health Care Representative to be perceived as an expression of distrust or a lesser level of confidence in other family members or other concerned persons.

With discussions in regard to the termination of life support treatment and other critical or emergency situations, I hereby authorize my Health Care Representative:

(Choose Yes or No)

____**YES** ____**NO:** To consult to the fullest extent possible, with all members of my immediate family or other group of persons I may choose, regarding my health care decisions, particularly those concerning withholding or withdrawal of treatment or of health care should I be in a terminal or irreversible condition.

____**YES** ____**NO:** To hold a conference with all willing and interested members of my immediate family or other group of persons I may choose, prior to making any decisions regarding termination of an artificial life support system.

____**YES** ____**NO:** To consult the following individual(s) regarding termination of artificial life support treatments.

If yes, which one? Indicate below:

____ Religious Clergy

____Medical professional

Other: _____

I direct that my Health Care Representative consider the following additional wishes and concerns prior to making any decisions regarding termination of artificial life support treatments:

_____

_____

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Instructions for My Health Care Representative

The following instructions provide you with guidelines regarding my wishes on the healthcare topics of my medical records, choice of physicians, medical tests, medications, and my preferences about healthcare facilities and long-term care.

If I am unable to act on my behalf, give direction, or consent, please use these guidelines in making wise decisions about my health care. You should not feel guilty or anxious about authorizing a course of action, because these are the decisions I would make if I were able to do so myself.

I realize that these instructions will not cover every medical situation that may arise, but it is my hope that these instructions will provide you with insight as to the actions I would have taken if I was able to make that choice for myself.

MEDICAL RECORDS

With regards to my medical records, I hereby authorize my Health Care Representative:

(Choose Yes or No)

____**YES** ____**NO:** To obtain and use my medical records during any time when my Health Care Representative is making medical decisions for me.

____**YES** ____**NO:** To take my medical records to another physician to obtain a second opinion before making a medical decision for me.

____**YES** ____**NO:** To share the information in my medical records with all the members of my immediate family or other group of persons I may choose. I am more concerned with consulting my loved ones than with the issue of privacy.

I direct that my Health Care Representative consider the following additional wishes and concerns prior to making any decisions regarding my medical records:

_____

_____

_____

_____

_____

_____

CHOICE OF PHYSICIANS

With regards to my choice of physicians, I hereby direct my Health Care Representative:

(Choose Yes or No)

____**YES** ____**NO:** To maintain and continue the relationship with my primary physician for as long as possible.

____**YES** ____**NO:** To obtain a referral for a quality specialist if my primary care physician is unable to provide medical treatment for any reason.

____**YES** ____**NO:** To seek treatment for me with a specialist in the area of my medical condition, whenever economically feasible.

I direct that my Health Care Representative consider the following concerns prior to making any decisions regarding my physicians:

_____

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_____

_____

_____

MEDICAL TESTS

With regard to the performing of medical tests, I hereby authorize my Health Care Representative:

(Choose Yes or No)

____**YES** ____**NO:** To allow any tests to be performed on me if, after consultation with my attending physician and/or appropriate specialists, the suggested test results are reasonably certain to be beneficial in restoring my health.

____**YES** ____**NO:** To obtain second opinions from an appropriate specialist, if economically feasible before authorizing or not authorizing any tests which my attending physician and/or primary care physicians believe would be beneficial in restoring my health.

I direct that my Health Care Representative consider the following additional wishes and concerns prior to making any decisions regarding medical tests:

_____

_____

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_____

MEDICATION/SPECIFIC LIFE PROLONGING PROCEDURES

With regard to the use of medications/specific life prolonging procedures, I hereby authorize my Health Care Representative:

(Choose Yes or No)

____**YES** ____**NO:** To consent to medication to relieve my pain, if my primary care physician and any appropriate specialists agree that the pain medication would not complicate or worsen my condition.

____**YES** ____**NO:** To use unconventional or experimental medication or therapy in my treatment.

____**YES** ____**NO:** To consider any possible side effects associated with unconventional or experimental medication or therapy. I specifically do not want a "cure" that is worse than the original illness.

____**YES** ____**NO:** To balance the cost of unconventional or experimental medication with the expected relief. I am concerned about the high costs often associated with these types of treatments.

(Choose Do or Do Not)

____**Do** ____**Do Not:** attempt resuscitation (DNR-Do Not Resuscitate)-if have no pulse AND I am not breathing.

____**Do** ____**Do Not:** provide artificial nutrition or hydration (tube feeding) to me, except for the provision of fluids to the extent necessary to deliver pain medication.

I would prefer the following medical interventions (please indicate one of wishes below):

_____ **Comfort Measures** (allow natural death). Treatment Goal: Maximize comfort through symptom management. Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. No transfer to hospital for life-sustaining treatments. Transfer to hospital only if comfort needs cannot be met in current location.

_____ **Limited Additional Interventions**. Treatment Goal: Stabilization of medical condition. In addition to care described above in Comfort Measures directly above, use medical treatment for stabilization, IV fluids (hydration), and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

_____ **Full intervention**. Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

ANTIBIOTIC USE/ARTIFICIAL NUTRITION

_____ Use antibiotics for infection only if comfort cannot be achieved fully through other means.

_____ Use antibiotics consistent with treatment needs.

_____ Artificially Administered Nutrition: Always offer food and fluid by mouth if feasible:

Choose one below:

____ No artificial nutrition.

_____Trial period of artificial nutrition by tube. Length of time: _____

____ Long-term artificial nutrition.

(Choose Yes or No)

_____**YES** _____**NO:** Power granted to my Health Care Representative to execute an Out-of-Hospital DNR (Do Not Resuscitate) if consistent with my wishes stated herein.

_____**YES** _____**NO:** Power of my Health Care Representative to execute a POST (Physician's Order and Scope of Treatment) if consistent with my wishes stated herein and I am a qualified patient for the POST form.

I direct that my Health Care Representative consider the following additional wishes and concerns prior to making any decisions regarding medication or any specific life prolonging procedures to supplement or explain choices above:

_____

_____

_____

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_____

HEALTH CARE FACILITY AND LONG-TERM CARE PREFERENCE

With regards to health care facilities and long-term care, I hereby authorize my Health Care Representative to consider the following preferences:

My preference is to maintain my current independent lifestyle for as long as possible. When I can no longer lead an independent lifestyle:

(Choose Yes or No)

____**YES** ____**NO:** My first choice is to remain in my home utilizing home-assistance services provided by an outside agency, family member or other person of my choice. (I realize that there may come a time when my desire to remain in my home may burden my loved ones' lives.)

____**YES** ____**NO:** My first choice is to reside with a family member or other person of my choice who is able and willing to take care of me in their home. (I realize that there may come a time when residing with my family member or other person of my choice may burden my loved one's life.)

____**YES** ____**NO:** I do not wish to burden my family members or other persons with my healthcare needs. When I can no longer maintain my independent lifestyle, with occasional assistance from outside agencies or a family member or other person of my choice, I wish to move to a long-term care facility which can provide me with the appropriate level of care.

HOME CARE

(Choose Yes or No)

____**YES** ____**NO:** I encourage my Health Care Representative to investigate and obtain home-assistance services from any or all of the following organizations: Visiting Nurses Association, Home Hospice Healthcare, Meal-on-Wheels, and any group that provides home assistant services.

____**YES** ____**NO:** When a family member or other person of my choice resides with me and provides the services necessary for me to remain in my home, I direct that no room or board fees shall be charged to this family member or other person of my choice.

____**YES** ____**NO:** During any time when a family member or other person of my choice resides with me and provides the services necessary for me to remain in my home, I direct my Health Care Representative visit my home (indicate below):

____At least every week

____Once every two weeks

Other time frame: _____

____**YES** ____**NO:** If my home cannot be used for any reason for home-assistance services provided by an outside agency, family member, or other person of my choice, I direct my Health Care Representative to determine if a family member or other person of my choice is able and willing to take care of me in their home.

____**YES** ____**NO:** During any time when a family member or other person of my choice provides home-assistance services and I reside with that family member or other person of my choice in their home, I direct my Health Care Representative visit the home (select below):

____At least every week

____Once every two weeks

Other time frame: _____

(Choose Yes or No)

____**YES** ____**NO:** During any time when my Health Care Representative believes that I can no longer receive appropriate care in my home, a family member's home, or the home of other person of my choice, I authorize my Health Care Representative to select for me and admit me into a nursing care facility.

I direct that my Health Care Representative consider the following additional wishes and concerns prior to making any decisions regarding care in my home and/or care in my family member's home, or the home of another person of my choosing:

_____

_____

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_____

_____

_____

INSTITUTIONAL CARE

(Choose Yes or No)

____**YES** ____**NO:** If I must reside at a long-term care facility, to the extent it is feasible and medically advantageous, I would prefer to reside in an assisted living facility until I require custodial care.

____**YES** ____**NO:** If I must reside at a long-term care or assisted-living facility, to the extent it is economically feasible and medically advantageous, I direct my Health Care Representative to select the following facility:

_____**(facility)**

____**YES** ____**NO:** If the above facility is not available or advisable in my Health Care Representative's sole discretion, my Health Care Representative should select a similar institution with the following qualities:

_____

_____

_____

_____

When selecting a long-term care facility, I direct my Health Care Representative to consider first (select below):

____Facilities located in the community where I live

____Facilities that are located in the community where the majority of my family or other concerned persons lives

Other considerations: _____

(Choose Yes or No)

____**YES** ____**NO:** When selecting a long-term care facility, I request that my Health Care Representative consult my family members to select a facility where my family members or other persons of my choice would feel comfortable visiting me.

____**YES** ____**NO:** I would prefer, if possible, a long-term care facility that is operated in accordance with my religious beliefs.

____**YES** ____**NO:** I direct that my Health Care Representative make at least two unannounced visits to any prospective nursing care facilities to determine if the services provided are acceptable.

____**YES** ____**NO:** My Health Care Representative shall consider the following factors: the credentials and abilities of care givers; the variety and nutritional value of meals; the type and frequency of visitors to the facility; and any other services my Health Care Representative shall determine important in the selection of a quality nursing care facility.

____**YES** ____**NO:** During anytime when I live in a nursing care facility, I direct that my Health Care Representative visit me (select below):

____At least every week

____Once every two weeks

____Other time frame: _____

I direct that my Health Care Representative consider the following additional wishes and concerns prior to making any decisions regarding institutional care:

_____
_____
_____
_____
_____

ANATOMICAL GIFTS/AUTOPSY

(Choose Yes or No)

____**YES** ____**NO:** I authorize my Health Care Representative to make anatomical gifts upon my passing.

____**YES** ____**NO:** I authorize my Health Care Representative to request an autopsy if deemed necessary and prudent under the circumstances.

ADDITIONAL WISHES

I direct that my Health Care Representative consider the following additional wishes and concerns prior to making any decisions regarding my care that is not covered above:

_____
_____
_____
_____

IN WITNESS WHEREOF, I have signed my name on this _____ day of _____, 20__.

_____
(SIGNATURE)

_____
(PRINTED)

STATE OF INDIANA)

COUNTY OF _____)

On the _____ day of _____ 20__, before me, the undersigned, a Notary Public in and for said County and State, personally appeared _____ known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to the within instrument, and acknowledged to me that said person executed the same.

WITNESS my hand and official seal.

_____ My Commission Expires: _____
Notary Public Signature

_____ My County of Residence: _____
Printed

I affirm, under the penalties for perjury, that I have taken reasonable care to redact each Social Security Number in this document, unless required by law. Glenn A. Deig, #13953-82

This instrument prepared by:

Glenn A. Deig, #13953-82
Certified Elder Law Attorney by the National Elder Law Foundation
Certified as an Estate Planning and Administration Specialist
By the Indiana State Bar Association
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