Advance Directives Packet
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Documents and Directives

Here is some good advice regarding the documents and directives you should prepare to cover circumstances where an illness or medical condition would render you incapable of making your own decisions regarding end-of-life care.

Documents You Should Have

- A living will
- A durable power of attorney for health care (surrogate)
- A letter to my physician
- DNR order (Do Not Resuscitate)

Where to Keep Your Documents

- Keep your Advance Directive (living will and appointment of surrogate form) in a conspicuous place in your home. **NEVER** place these documents in a safe deposit box since they will not be readily available when needed.

Who Should Have A Copy

- Your surrogate and alternate surrogate(s)
- Your nearest relatives
- Your physician (make certain these documents are placed in your file)
- Your attorney
- The medical facility where you have a medical record and would go if hospitalized. It is also a good idea to keep copies in your car and to have a label on the glove compartment or driver's license that reads "living will on file." You may also want to put a similar label on your home's entrance or on the refrigerator door.
- All copies of your Advance Directive should be signed in **BLUE** ink by you, even though the text may be a photocopy. A photocopied signature is not a legal document.

Where You Can Obtain These Document

- You can obtain an Advance Directive (living will and appointment of surrogate) at no cost from your local hospital, several websites or from Hemlock Society of Florida, Inc., P.O. Box 121093, West Melbourne, FL 32912-1093. Enclose a self-addressed, stamped #10 business envelope. If you would like the complete Advance Directive packet, send a 9" x 12" self-addressed, stamped envelope.

Do Not Resuscitate Order

- A pre-hospital DNR order can also be obtained from the Hemlock Society of Florida at the above address, your physician, or the Florida Dept of Health. The DNR order is yellow/goldenrod in color and must be signed by you and the physician. If you are admitted to the hospital you may need to complete an in-hospital DNR.

If You Are A Patient, You Have the Right:

- to have an Advance Directive (living will and appointment of surrogate forms) with the expectation that your attending physician and the hospital will honor its provisions as required by law
- to receive answers to your health care questions for any provider of services
- to be a fully informed participant in health care decisions
- to obtain a clear explanation of all proposed procedures, their risks and side effects, potential problems in recovery, probability of success and ultimate effect on quality of life and prognosis
- to discuss your condition with another doctor or specialist at your request and expense. This may or may not be paid for by your insurance carrier.
- To access all information in your medical record.

If You Are Hospitalized, You have the Right:

- to a complete evaluation of your medical condition and your prognosis, with or without treatment, before you consent to any additional test or procedure
- to refuse any particular drug, test, procedure or treatment
- to have access to visitors and to others by phone
- to privacy regarding information about your medical condition and treatment
- to leave the hospital regardless of your physical condition. You may be asked, but cannot be required, to sign a release saying you do so againse your physician's best judgment.
- To stay in the hospital if you feel you are too sick to leave. Your insurance may not cover the extended stay.
- To be informed of what your health care requirements will be after you leave the hospital
- To receive a complete copy of information in your medical record after you leave the hospital. You will have to ask for it and there will probably be a fee for this service.

If You Are Terminally Ill, You Have the Right:

- to demand that no one in your family be told of your terminal prognosis, if that is your wish
- to refuse treatment even if you will die without it. To demand and to receive adequate medication for pain control even if it will shorten your life.

In emergency-care situations (emergency room, paramedics), it is imperative that you have your medical directive and/or the person designated as you surrogate with you to make sure your rights are honored. Otherwise standard emergency procedures will be followed. If you do not wish to be resuscitated, be certain the DNR order is available. There is a "tear-off" portion of the DNR form which can be laminated and attached to a chain to be worn as a necklace so that the DNR is with you at all times.

Definitions

(1) "Advance directive" means a witnessed written document or oral statement in which instructions are given by a principal or in which the principal's desires are expressed concerning any aspect of the principal's health care, and includes, but is not limited to, the designation of a health care surrogate, a living will, or an anatomical gift made pursuant to part X of chapter 732.

(2) "Attending physician" means the primary physician who has responsibility for the treatment and care of the patient.

(3) "Close personal friend" means any person 18 years of age or older who has exhibited special care and concern for the patient, and who presents an affidavit to the health care facility or to the attending or treating physician stating that he or she is a friend of the patient; is willing and able to become involved in the patient's health care; and has maintained such regular contact with the patient so as to be familiar with the patient's activities, health, and religious or moral beliefs.

(4) "End-stage condition" means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

(5) "Health care decision" means:

(a) Informed consent, refusal of consent, or withdrawal of consent to any and all health care, including life-prolonging procedures.

(b) The decision to apply for private, public, government, or veterans' benefits to defray the cost of health care.

(c) The right of access to all records of the principal reasonably necessary for a health care surrogate to make decisions involving health care and to apply for benefits.

(d) The decision to make an anatomical gift pursuant to part X of chapter 732.

(6) "Health care facility" means a hospital, nursing home, hospice, home health agency, or health maintenance organization licensed in this state, or any facility subject to part I of chapter 394.

(7) "Health care provider" or "provider" means any person licensed, certified, or otherwise authorized by law to administer health care in the ordinary course of business or practice of a profession.

(8) "Incapacity" or "incompetent" means the patient is physically or mentally unable to communicate a willful and knowing health care decision. For the purposes of making an anatomical gift, the term also includes a patient who is deceased.

(9) "Informed consent" means consent voluntarily given by a person after a sufficient explanation and disclosure of the subject matter involved to enable that person to have a general understanding of the treatment or procedure and the medically acceptable alternatives,

including the substantial risks and hazards inherent in the proposed treatment or procedures, and to make a knowing health care decision without coercion or undue influence.

(10) "Life-prolonging procedure" means any medical procedure, treatment, or intervention, including artificially provided sustenance and hydration, which sustains, restores, or supplants a spontaneous vital function. The term does not include the administration of medication or performance of medical procedure, when such medication or procedure is deemed necessary to provide comfort care or to alleviate pain.

(11) "Living will" or "declaration" means:

(a) A witnessed document in writing, voluntarily executed by the principal in accordance with s. 765.302; or

(b) A witnessed oral statement made by the principal expressing the principal's instructions concerning life-prolonging procedures.

(12) "Persistent vegetative state" means a permanent and irreversible condition of unconsciousness in which there is:

(a) The absence of voluntary action or cognitive behavior of any kind.

(b) An inability to communicate or interact purposefully with the environment.

(13) "Physician" means a person licensed pursuant to chapter 458 or chapter 459.

(14) "Principal" means a competent adult executing an advance directive and on whose behalf health care decisions are to be made.

(15) "Proxy" means a competent adult who has not been expressly designated to make health care decisions for a particular incapacitated individual, but who, nevertheless, is authorized pursuant to s. 765.401 to make health care decisions for such individual.

(16) "Surrogate" means any competent adult expressly designated by a principal to make health care decisions on behalf of the principal upon the principal's incapacity.

(17) "Terminal condition" means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

History.--s. 2, ch. 92-199; s. 3, ch. 94-183; s. 46, ch. 96-169; s. 16, ch. 99-331; s. 3, ch. 2001-250; s. 131, ch. 2001-277.

Florida Statute Ch. Title XLIV, ch. 765.101

Guidelines for Completing A Living Will

A Living Will is a legal document that states your wishes (how you want to be treated) for end-of-life care. It is different from a Will, which designates the disposition of your financial estate after you have died. These are both very important documents you should execute.

1. While you are still in good health and mind, discuss your end-of-life care with your family. Be firm in expressing YOUR wishes.

2. When appointing a Surrogate for Health Care, discuss your wishes with your designee and make certain that person will carry out your wishes. If they hesitate about this, choose another person who will carry out your wishes. Make certain that your appointed surrogate understands your wishes.

3. Don't be afraid to discuss your end-of-life care with your primary physician and any other doctors who may be treating you. You have a right to know your condition and any course of treatment suggested. You have a right to refuse or withdraw treatment. Know the options.

4. Once you have completed your Living Will, make as many copies as you will need and then sign and witness all copies in **BLUE** ink. Give a copy to each of your doctors, family members, your surrogate, your lawyer, and your spiritual advisor.

5. When completing a Living Will you may also want to have a Pre-Hospital Do Not Resuscitate (DNR) Order. A physician must complete and sign the DNR Order. Discuss this matter with your doctor. (If admitted to a medical facility, you may need to complete the facility's DNR form.)

6. On October 1, 1999 the Florida Living Will was updated to include end-stage condition and persistent vegetative state, in addition to terminal illness.

REMEMBER: DO NOT put your Will or your Living Will in a safe deposit box. These documents will not be available when most needed.

Responsibility of the surrogate.--

(1) The surrogate, in accordance with the principal's instructions, unless such authority has been expressly limited by the principal, shall:

(a) Have authority to act for the principal and to make all health care decisions for the principal during the principal's incapacity.

(b) Consult expeditiously with appropriate health care providers to provide informed consent, and make only health care decisions for the principal which he or she believes the principal would have made under the circumstances if the principal were capable of making such decisions. If there is no indication of what the principal would have chosen, the surrogate may consider the patient's best interest in deciding that proposed treatments are to be withheld or that treatments currently in effect are to be withdrawn.

(c) Provide written consent using an appropriate form whenever consent is required, including a physician's order not to resuscitate.

(d) Be provided access to the appropriate medical records of the principal.

(e) Apply for public benefits, such as Medicare and Medicaid, for the principal and have access to information regarding the principal's income and assets and banking and financial records to the extent required to make application. A health care provider or facility may not, however, make such application a condition of continued care if the principal, if capable, would have refused to apply.

(2) The surrogate may authorize the release of information and medical records to appropriate persons to ensure the continuity of the principal's health care and may authorize the admission, discharge, or transfer of the principal to or from a health care facility or other facility or program licensed under chapter 400.

(3) If, after the appointment of a surrogate, a court appoints a guardian, the surrogate shall continue to make health care decisions for the principal, unless the court has modified or revoked the authority of the surrogate pursuant to s. 744.3115. The surrogate may be directed by the court to report the principal's health care status to the guardian.

History.--s. 3, ch. 92-199; s. 9, ch. 94-183; s. 50, ch. 96-169; s. 23, ch. 99-331; s. 11, ch. 2000-295; s. 6, ch. 2001-250; s. 135, ch. 2001-277.

Florida Statute, Title XLIV, ch. 765.205

ADVANCE DIRECTIVES

FOR

_____

Designation of Health Care Surrogate
Living Will
And Other Wishes

With this form I have appointed the person I want to make medical decisions for me if, in the future, I am unable to make those decisions for myself. I am also indicating the health care I do or do not want if, in the future, I am unable to make my wishes known.

Provided by
Hemlock Foundation of Florida, Inc.
P. O. Box 121093
West Melbourne, FL 32912-1093

Designation of Health Care Surrogate

Name:

_____

PRINT: (Last) (First) (Middle Initial)

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: _____

Address: _____

_____

Phone: _____

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

Name: _____

Address: _____

_____

Phone: _____

I fully understand that this designation will permit my designee to:

1. make health care decisions for me, except for anatomical gifts, unless I have executed an anatomical gift declaration pursuant to law;
2. provide, withhold, or withdraw consent on my behalf;
3. apply for public benefits to defray the cost of health care; and
4. authorize my admission to or transfer from a health care facility.

Taken from FL statute Title XLIV, Ch. 765-203

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 may know who my surrogate is.

Name(s) and address(es):

_____

_____

_____

_____

_____

_____

Signed: _____ Date: _____

Witnesses: 1. _____
(Signature)

2. _____
(Signature)

_____

Hemlock Foundation of Florida, Inc.
1-800-849-9349 • P. O. Box 121093, W. Melbourne, FL 32912-1093 • www.hemlockflorida.org

Living Will

Declaration made this _____ day of _____, _____, 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 incapacitated and

_____ I have a terminal condition
(initial)

or _____ I have an end-stage condition
(initial)

or _____ I am in a persistent vegetative state
(initial)

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

It is my intention 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 of such refusal.

In the event that 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 to carry out the provision of this declaration:

Name:_____

Address:_____

_____
(Zip Code)

Phone:_____

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

If I have a terminal condition or an end-stage condition or am in a persistent vegetative state and there is no reasonable medical probability of my recovery from such condition *(initial one)*:

_____ I do NOT want life-prolonging procedures, including artificially provided nutrition and hydration and cardiopulmonary resuscitation (CPR) started. If such procedures have been started, I want them stopped.

_____ I want any life-prolonging procedures that my doctors think are best for me.

Taken from FL statute XLIV, Ch. 765-303

If I am in any of the conditions described above, I feel very strongly about the following forms of treatment (initial your wishes):

	I do NOT want	I DO want
cardiopulmonary resuscitation (CPR)	_____	_____
mechanical respiration (ventilation)	_____	_____
tube feeding or any other artificial or invasive form of nutrition (food) or hydration (water)	_____	_____
blood or blood products	_____	_____
any form of surgery or invasive diagnostic tests	_____	_____
kidney dialysis	_____	_____
Antibiotics	_____	_____

Comfort Care *(initial if this is your wish)*

_____ I want to be kept as comfortable and free of pain and suffering as possible, even if such care hastens my death. I expect relief of any pain and suffering that results from my refusal of treatment. For agitation I want sedation, not physical restraint.

NOTE: I am aware that I have the right to be involved in all decisions about my medical care, including those not dealing with terminal or end-stage conditions or persistent vegetative state.

Additional Instructions (optional):

_____

_____

_____

OTHER WISHES:

Organ Donation *(initial one)***:**

_____ I do NOT wish to donate any of my organs or tissues

_____ I want to donate all of my organs and tissues

_____ I want to donate only these organs and tissues: _____

_____

Other wishes: _____

_____

Taken from FL statute XLIV, Ch. 765-303

Autopsy *(initial one)***:**

_____ I do NOT want an autopsy

_____ I agree to an autopsy if my doctors request it

SIGNATURES

My signature:

By my signature below I show that I understand the purpose and effect of this document.

Signature: _____

Print Name: _____ Date _____

Address: _____

Phone: _____

Signature of Two Witnesses:

One witness shall not be a spouse or blood relative, and the person(s) you appoint as surrogate(s) cannot act as witnesses.

WITNESS 1:

Signature: _____

Print Name: _____

Address:_____

_____

Phone: _____

WITNESS 2:

Signature: _____

Print Name: _____

Address:_____

_____

Phone: _____

(These two addenda are not part of the Florida Statute.)

ADDENDUM TO MY LIVING WILL:
(For permanent Florida residents)

This Declaration shall be construed under the Laws of Florida. In the event a medical treatment decision is made for me under this declaration and in the further event that I should be physically located outside the State of Florida, Florida Law shall apply. If, in the sole judgment of my surrogate, such medical treatment decision which would be permitted in the State of Florida may not or will not be permitted in the jurisdiction in which I am then present I authorize and direct my surrogate to immediately transport my physical person to the State of Florida.

_____ _____
Signature Date

****

ADDENDUM TO MY LIVING WILL:

If I become incompetent, I hereby demand that nutrition and hydration be withheld from me, that I be kept comfortable, and that the person designated as my health care agent (proxy or surrogate) enforce these wishes. I direct that payment be refused for any treatment that violates these wishes.

In the event that physician aid-in-dying becomes legal in my state of residence I hereby direct that I be given lethal medication in preference to withdrawal of nutrition and hydration.

_____ _____
Signature Date

Important!
In order to be legally valid this form MUST be printed on yellow paper prior to being completed. EMS and medical personnel are only required to honor the form if it is printed on yellow paper.

This box will not show up when the form is printed.

FLORIDA DEPARTMENT OF HEALTH

State of Florida
DO NOT RESUSCITATE ORDER

(please use ink)

Patient's Full Legal Name: _____Date:_____
(Print or Type Name)

PATIENT'S STATEMENT

Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn.
(If not signed by patient, check applicable box):

❑ Surrogate
❑ Court appointed guardian
❑ Proxy (both as defined in Chapter 765, F.S.)
❑ Durable power of attorney (pursuant to Chapter 709, F.S.)

_____
(Applicable Signature) (Print or Type Name)

PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

_____
(Signature of Physician) (Date) Telephone Number (Emergency)

_____
(Print or Type Name) (Physician's Medical License Number)

DH Form 1896, Revised December 2002

PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

_____
(Signature of Physician) (Date) Telephone Number (Emergency)

_____
(Print or Type Name) (Physician's Medical License Number)

DH Form 1896,Revised December 2002

FLORIDA DEPARTMENT OF HEALTH

State of Florida
DO NOT RESUSCITATE ORDER

_____
Patient's Full Legal Name (Print or Type) (Date)

PATIENT'S STATEMENT

Based upon informed consent, I, the undersigned,hereby direct that CPR be withheld or withdrawn. **(If not signed by patient, check applicable box):**

❑ Surrogate
❑ Proxy (both as defined in Chapter 765, F.S.)
❑ Court appointed guardian
❑ Durable power of attorney (pursuant to Chapter 709, F.S.)

_____
(Applicable Signature) (Print or Type Name)

A Letter to My Physician Concerning My Decision About Physician Aid-in-Dying

(This is a model letter that you can use to convey your end-of-life wishes to your doctor. It should be accompanied by a copy of your Designation of Health Care Surrogate and Living Will.)

Dear Dr. _____:

I wish to inform you that I believe in and fully support the concept of physician aid-in-dying for individuals who are terminally ill or have an end-stage condition or are in a permanent vegetative state. If a time comes when I am suffering from an incurable and/or terminal illness, and choose to end my suffering, I wish to have physician aid-in-dying.

I have fully considered this issue. I believe I have the right to control the time and manner of my own death.

I have completed a Designation of Health Care Surrogate and a Living Will. I will provide you with a copy of each document. I realize, however, that withholding or withdrawing medical treatment as authorized by these documents may not shorten the time of my dying as I wish. Regardless of whether or not such withholding/withdrawing would affect my time of dying, I want the option of physician aid-in-dying if it is then legal.

_____
Signature

_____
Date

Physician's Acknowledgement of Receipt of Advance Directives for Health Care Decisions

This is to acknowledge receipt of the following forms which have been executed by the declarant on _____, _____ .

Name: _____

Address: _____

_____

Phone: _____

1. Living Will
2. Appointment of Health Care Surrogate
3. Organ Donor Form
4. Other Wishes for End-of-Life Care

I agree that in the event the declarant shall become incompetent to make his/her own medical decisions and/or shall become terminally ill, in a persistent vegetative state or in an end-stage condition and if I shall be the attending physician, I will exert my best efforts to effectuate his/her desires as expressed in these documents.

Signed:_____ Date: _____

Print Name: _____

Acceptance of Appointment as Surrogate for Health Care Decisions

This is to acknowledge that I have read the Living Will, Appointment of Surrogate for Health Care Decisions, Organ Donor form and Other Wishes by _____ of_____ , in which I am named as Surrogate to make health care decisions for the declarant in the event that he/she is unable to do so for himself/herself. I have discussed this matter with the declarant and have agreed to serve as his/her Surrogate under such circumstances. I will exert every effort to implement the desires of the declarant as expressed in these documents.

I understand that I must act in good faith and that this designation shall become effective only in the event that the declarant becomes incompetent to make his/her own health care decisions.

_____

(Signature of Surrogate for Health Care Decisions)

_____

(Print Name)

Date: _____

Acceptance of Appointment as Alternate Surrogate for Health Care Decisions

This is to acknowledge that I have read the Living Will, Appointment of Alternate Surrogate for Health Care Decisions, Organ Donor form and Other Wishes executed by _____ of _____ in which I am named as Alternate Surrogate to make health care decisions for the declarant in the even that he/she is unable to do so for himself/herself. I have discussed this matter with the declarant and have agreed to serve as his/her Alternate Surrogate under such circumstances. I will exert every effort to implement the desires of the declarant as expressed in these documents.

I understand that I must act in good faith and that the designation shall become effective only in the event that the declarant becomes incompetent to make his/her own health care decisions.

_____

(Signature of Alternate Surrogate for Health Care Decisions)

_____

(Print Name)

Date:_____