Advance Directives

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Understanding Advance Directives

A Guide for Patients and Families

It can be hard for doctors and loved ones to know what kind of medical treatment you would want if you were too sick to express your wishes. What would be important to you? Would you want to prolong life, regardless of pain and a slim chance of recovery? Would you want to act according to your religious beliefs? What are those beliefs? Are there any medical procedures you would not want performed? Would you want to be with your loved ones if you were dying? By thinking about these questions ahead of time and reflecting on your values, you can guide the direction of your healthcare.

What Is an Advance Directive?

An advance directive is a legal form that tells your doctors and loved ones what kind of medical care you want (or do not want) if you are too sick or injured to speak for yourself. You might choose to complete one, two, or all three of these forms. This booklet provides information to help you decide what will best serve your needs.
It usually includes:

- **A Living Will** – indicates your wishes about medical treatments if you can't speak for yourself such as life support, tube feeding, or ventilators.
- **Health Care Surrogate (or Proxy)** Designation - a person you choose to make healthcare decisions for you if you cannot.
- **An Anatomical Donation (Donor Form)** – indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for medical training and research.

What Is a Living Will?

A Living Will is a document that explains your wishes about medical care if you are unable to make decisions for yourself.

Specifies your preferences for life-sustaining treatments such as:

- CPR (resuscitation)
- Ventilators or breathing machines
- Tube feeding or hydration
- Other medical interventions in serious illness or end-of-life situations

What Is a Health Care Surrogate?

Your **Health Care Surrogate** (also called an agent) is the person you trust to step in your shoes on your behalf and make medical decisions that reflect your wishes when you are not able to. Under Florida Statutes 765.202, any competent adult—defined as at least 18 years old and mentally capable—may be designated

This person should:

- Know your values, beliefs, and medical wishes.
- Be comfortable talking with doctors and family members.
- Be able to make decisions on your wishes, and not on their own personal preference of beliefs.
- Be ready to make decisions during stressful times.

What Is an Anatomical Donation?

It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of health care workers.
You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form (seen elsewhere in this pamphlet), or expressing your wish in a living will.

How It Helps You

- Makes sure your wishes are followed when you can't speak for yourself.
- Helps your family and doctors understand what care you want.
- Reduces stress and confusion for loved ones during emergencies.
- Gives you peace of mind knowing your choices are known and respected.

Must an Attorney Prepare the Advance Directive?

- No, the procedures are simple and do not require an attorney, though you may choose to consult one.
- However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative

Choosing the Right Advance Directive

- You can complete:

  - A Living Will, to state what treatments you want.
  - A Health Care Surrogate Designation form, to name someone to decide for you.
- You may complete both.
- You can change or cancel your directive anytime.

Advantages of Having One

- Protects your right to choose your care.
- Prevents unwanted medical treatments.
- Reduces family disagreements.
- Helps your doctors know exactly what to do.
- Gives you control and comfort over future healthcare decisions.

What is the Role of a Health Care Surrogate

- Speak to doctors for you.
- Review medical information.
- Approve or decline treatments based on your wishes.
- Ensure your advance directive is followed.
- Make decisions based on your wishes only when you can’t.

What should I do with my Advance Directive?

Give copies of your advance directive to:

- Your doctor
- Your health care surrogate/agent
- Close family members
- Keep one in an easy-to-find place at home

What if I need to change my Advanced Directive?

You can always change or cancel your advance directives. Any changes should be written, signed and dated. It is important that you review the documents regularly to make sure that they clearly reflect your current thoughts. If something changes, you can complete new forms and notify those responsible for carrying out your healthcare wishes

More Information on Health Care Advance Directives

Before deciding about advance directives you might want to consider additional options and other sources of information, including the following:

- As an alternative to a health care surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information or read Chapter 709, Florida Statutes.

If you choose someone as your durable power of attorney be sure to ask the person if he or she will agree to take this responsibility, discuss how you would like matters handled, and give the person a copy of the document.

- If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest. The pre-hospital DNRO is a specific yellow form available from the Florida Department of Health (DOH). Your attorney, health care provider, or an ambulance service may also have copies available for your use. You, or your legal representative, and your physician sign the DNRO form. More information is available at Florida Department of Health or www.MyFlorida.com (type DNRO in these website search engines).

When you are admitted to a hospital the pre-hospital DNRO may be used during your hospital stay or the hospital may have its own form and procedure for documenting a Do Not Resuscitate Order.

- If you would like to learn more on organ and tissue donation, please visit the Joshua Abbott Organ and Tissue Donor Registry at www.DonateLifeFlorida.org where you can become organ, tissue and eye donors online.
- Various organizations also make advance directive forms available. You can find out more at:

  - Florida Agency for Health Care Administration
    https://quality.healthfinder.fl.gov/report-guides/advance-directives
    (888) 419-3456
  - Aging with Dignity – Five Wishes
    www.AgingWithDignity.org
    (888) 594-7437
  - American Association of Retired Persons (AARP)
    www.aarp.org
    (Type “advance directives” in the website’s search engine)

Your local hospital, nursing home, hospice, home health agency, and your attorney or health care provider may be able to assist you with forms or further information.

The card below may be used as a convenient method to inform others of your health care advance directives. Complete the card and cut it out. Place in your wallet or purse.
You can also make copies and place another one on your refrigerator, in your car glove compartment, or other easy to find place.

ADVANCE DIRECTIVES CARD

I,

Have created the following Advance Directives:

- ☐ Living Will
- ☐ Health Care Surrogate Designation
- ☐ Anatomical DOnation
- ☐ Other (specify)

FOLD

Name _____

Address _____

_____

Phone _____

Signature _____

Agency for Health Care Administration

2727 Mahan Drive, Tallahassee, Florida 32308 | 1-888-419-3456

www.FloridaHealthFinder.gov | www.MyFloridaRx.com

http://ahca.myflorida.com 04-2006

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Living Will

Pursuant to Florida Statutes § 765.202

Name: _____ **Date of birth:** ___/___/____ .

Adress: _____

I, the undersigned, make this declaration to provide guidance to my doctors and loved ones regarding my medical care if I am unable to make my own healthcare decisions.

Statement of Wishes
If I am terminally ill, permanently unconscious, or unable to make decisions, I request that medical treatment be provided in accordance with the following preferences:

- **Life-sustaining treatments:**
  ☐ I do not want life-sustaining treatments if they only prolong the dying process.
  ☐ I do want all possible treatments to prolong life, if appropriate.
- **Resuscitation (CPR):**
  ☐ I do not want CPR (Do Not Resuscitate).
  ☐ I want CPR if my heart stops.
- **Mechanical ventilation (breathing machine):**
  ☐ I do not want mechanical ventilation if I cannot breathe on my own.
  ☐ I want mechanical ventilation if medically appropriate.
- **Tube feeding or hydration:**
  ☐ I do not want artificial nutrition or hydration if I cannot eat or drink.
  ☐ I want artificial nutrition and hydration if medically appropriate.
- **Pain relief and comfort care:**
  ☐ I want pain relief and comfort care at all times, even if it may hasten death.

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 for such refusals.

I understand that I can **revoke or change** this Living Will at any time while I am competent.

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

Firma: _____ **Date:** ___/___/____ .

Witnesses (Florida law requires two witnesses, at least one witness must not be a spouse or a blood relative of the principal, or someone entitled to inherit)

1. **Witness name:** _____ **Signature:** _____ **Date:** ___/___/____.

2. **Witness name:** _____ **Signature:** _____ **Date:** ___/___/____.

cut along the dotted line

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Designation of Health Care Surrogate

Pursuant to Florida Statutes § 765.202

Name of Principal: _____ **DOB:** ___/___/____.
(the person making this designation)

Address: _____

In the event that I am determined to be incapacitated and unable to provide informed consent for medical treatment, surgical procedures, or diagnostic care, I designate the following individual to make health care decisions on my behalf:

- **Name:** _____
- **Address:** _____
- **Phone:** _____ **Email:** _____

If my primary surrogate is unwilling or unable to act, I designate the following individual to serve as my **Alternate Health Care Surrogate(s):**

- **Name:** _____
- **Address:** _____
- **Phone:** _____ **Email:** _____

- **Name:** _____
- **Address:** _____
- **Phone:** _____ **Email:** _____

I understand that this designation authorizes my health care surrogate to make medical decisions for me, including providing, withholding, or withdrawing consent for medical care and treatment; applying for public benefits to help pay for my health care; and authorizing my admission to or transfer from a health care facility.

Additional Instructions (optional): _____

_____

This designation is not made as a condition of treatment or admission to a health care facility. I will provide copies of this form to those listed below, so they are aware of my health care surrogate.

Name of additional contact (optional)

_____

SIgnature: _____ **Date:** ___/___/____.

Witnesses: 1. _____ **2.** _____

(At least one witness must not be a spouse or a blood relative of the principal.)

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Uniform Donor Form

Name: _____ **DOB:** __/__/__.__

Address: _____

The undersigned hereby makes this anatomical gift, if medically acceptable, to take effect on death.

☐ I wish to donate any organ and tissue

☐ I wish to donate only the following organs or tissue:

☐ Kidneys	☐ Liver	☐ Pancreas	☐ Lungs
☐ Eyes / Corneas	☐ Bone Tissue	☐ Skin Tissue	☐ Heart

☐ I wish NOT to donate any organ or tissue

☐ I wish to donate my body for anatomical study, if needed. Limitations or special wishes, if any:

_____

_____

☐ My gift of organs and tissues **MAY NOT** be used for medical research.

Signed by the donor and the following witnesses in the presence of each other:

- **Name:** _____
- **Address:** _____
- **Phone:** _____ **Email:** _____

- **Name:** _____
- **Address:** _____
- **Phone:** _____ **Email:** _____

- **Name:** _____
- **Address:** _____
- **Phone:** _____ **Email:** _____

You can use this form to indicate your choice to be an organ donor or you can designate it on your driver's license or state identification card (at your nearest driver's license office)

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Other resources include:

www.agingwithdignity.org

Aging with Dignity **888.594.7437**

www.FloridaHealthFinder.gov

(click Brochures and Guides)

888.419.3456

American Association of Retired Persons (AARP)

www.aarp.org

(Type “advance directives”
in the website’s search engine).

For more information, please call

LEON MEDICAL CENTERS

Costumer Service:

305.642.5366

OR

Talk to your doctor about other alternatives.