ADVANCED DIRECTIVE

1) Living Will Declaration

I, _____, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below. I do hereby declare that if at any time I should have a terminal condition as defined by Florida Statute, and my attending physician has determined that procedures would serve only to artificially prolong the dying process, I direct such procedures to be withheld or withdrawn. It is my wish that I be permitted to die naturally with the administration of medication or performance of the medical procedures deemed necessary to provide me with comfort care or to alleviate pain.

☐ I DO ☐ I DO NOT ….want to have the tube taken out of my nose or mouth that is connected to a machine that is breathing for me if it has already been inserted.

☐ I DO ☐ I DO NOT …..want to have the tube that is feeding me removed from my nose, mouth or stomach if it has already been inserted.

☐ I DO ☐ I DO NOT .....want CPR.

☐ I DO ☐ I DO NOT ….want a tube placed in my nose or mouth and connected to a machine to breathe for me.

☐ I DO ☐ I DO NOT ….want a tube in my nose or mouth, or surgically placed in my stomach, that is connected to a hanging bag to give me food.

☐ I DO ☐ I DO NOT ….want to have a needle or catheter placed in my body and connected to a hanging bag to give me water and other fluids.

☐ I DO ☐ I DO NOT .....want to die naturally. (To die naturally means I will receive only medicine and treatment that will keep me comfortable. This also means no antibiotics or other treatments that delay my death. I know this care could have side effects that could cause me to die sooner.)

In the absence of my ability to give directions regarding the use of such life-prolonging procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this declaration shall have no force of effect during the course of my pregnancy.

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

Signed _____ **Date** _____/_____/_____
Witness _____ **Date** _____/_____/_____
Witness _____ **Date** _____/_____/_____

In addition to the provisions of my living will, or instead of a living will, I would like to designate a healthcare surrogate. My healthcare surrogate will have the authority to provide consent for medical treatment and surgical and diagnostic procedures if I am incapacitated and unable to provide such consent myself.

☐ YES ☐ NO If YES, complete next page; if NO, STOP here.

2) Healthcare Surrogate Designation

I, _____, would like to name as my healthcare surrogate:
Name _____
Address _____ Zip _____
Phone: (day) _____ (Evening) _____

If my surrogate is unwilling or unable to perform his duties, I wish to designate as my alternate surrogate: (optional)
Name _____
Address _____ Zip _____
Phone: (day) _____ (Evening) _____

I understand that my healthcare surrogate cannot override any specific wishes I have listed in my living will, but can make healthcare decisions on my behalf in situations not specifically addressed by me in my living will.
Initial: _____

I understand that I need only be incapacitated and unable to make medical decisions for my healthcare surrogate to assume authority.
Initial: _____

I fully understand that this designation will permit my surrogate to make healthcare decisions and to provide, withhold, or withdraw consent on my behalf, to apply for public benefits to defray the cost of healthcare and to authorize my admission to or transfer from a healthcare facility. I further affirm that this designation is not being made as a condition of treatment or admission to a healthcare facility.

Signed _____ Date _____/_____/_____
Witness _____ Date _____/_____/_____
_____ Date _____/_____/_____

One witness CANNOT be a spouse or blood relative. The person designated as surrogate CANNOT be a witness. Keep the original of this document in a safe place where your family and designated surrogates have access to it. Give copies to your designated surrogates, physician, family, minister/rabbi/priest and anyone else you feel is appropriate. Please review annually and initial and date.

Reviewed and updated:
Initial _____ Date _____
Initial _____ Date _____
Initial _____ Date _____