Please read the instructions before filling out this form.
This form emphasizes quality of life.

ADVANCE HEALTH CARE DIRECTIVE

(Living Will with Durable Power of Attorney for Health Care)

THE TERMS OF MY DIRECTIVE ARE ON PAGES 2-3

My Name is:_____ _____
Full Name Preferred First Name

My Agent (Surrogate or Proxy) is: _____

Agent's Phone Numbers:_____
Cell Home Work
Address:_____

My Alternate Agents are: (If the designated agent is unwilling or unable to serve) (Optional)
1st Alternate: Name: _____
Phone Numbers:_____
Address: _____

2nd Alternate: Name: _____
Phone Numbers: _____
Address: _____

My Primary Physician is :
Dr. _____
Phone:_____
Address:_____

THE KEY TERMS OF MY DIRECTIVE ARE ON PAGE 2
Date and Signature are on page 3

My Name Is: _____

AUTHORITY OF MY AGENT: When I am unable to make my own decisions, my Agent has authority to make all medical decisions for me, except as may be stated below. This means to agree to, to refuse, withdraw or consent to any medical care, such as surgery, medications, or procedures, even if deciding to stop or withhold treatment might hasten my death.

INSTRUCTION TO MY AGENT: I have discussed my philosophy, goals and wishes with you. My choices below reflect them. If the choice I would make in any given circumstance is unclear, you are instructed to decide based on what you believe to be in **my best interest**, given my philosophy, goals and wishes known to you.

You, my Agent, (initial one) _____are authorized, or _____are NOT authorized to override any specific decisions stated in this Advance Health Care Directive (If neither is initialed then my Agent is authorized).

You, my Agent, (initial one) _____are, _____are NOT to be involved in my health care decisions even if I am competent to make the decisions on my own. (If neither is initialed then my Agent is authorized).

INSTRUCTIONS TO MY AGENT AND TO MY PERSONAL AND ATTENDING PHYSICIANS:
The **QUALITY of my LIFE** is more important to me than living as long as possible.
I understand that doctors, nurses and others have a professional obligation to keep me alive. It is my directive that such obligation is less important than my autonomy as expressed by my choices below.

Always apply palliative care.

If I am in an institution or any facility that refuses to carry out my directives, then move me home or to a facility that will.

INITIAL ALL THAT APPLY: (These choices are progressive; check as far down as you wish.)
1. _____**VEGETATIVE STATE**. I do not wish to live either in a vegetative or a near-vegetative state from which I am unlikely to recover.
2. _____**TIME-LIMITED TRIALS**. I authorize time-limited trials to see if medical interventions might return me to the minimum quality of life I desire, as discussed with my agent. How long a trial goes is to be determined by my agent, in consultation with doctors.
3. _____ **DISCONTINUE MEDICAL INTERVENTIONS.** If it appears that medical interventions are prolonging my life but not returning me to the quality of life I desire, then discontinue the interventions and begin comfort care only.
4. _____ **ASSISTED FEEDING**. If I am unable to feed myself, then spoon feed me whatever I seem to enjoy, and no more. Do not feed me or apply medical interventions, such as tubes and IVs, so that I might live longer.
5. _____ **WITHHOLD NUTRITION & HYDRATION** if I show no desire to eat and/or drink. This includes medical interventions such as tubes and IVs.
6. _____ **EVEN IF I SHOW A DESIRE TO EAT OR DRINK**, withhold ALL nutrition & hydration.
7. _____ **IGNORE** my utterances or other indication that I wish to eat and/or drink.

My Name Is: _____

CONSERVATORSHIP/GUARDIANSHIP: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form.

IN ADDITION: Optional. See the instructions for possibilities.
To the person completing this form: The following lines are for you to make additions or changes to your choices above. Also, if you choose one or more options above, A, B, C ,D, E and/or F (page 2), you may wish to state here what a minimum quality of life means to you, especially if you choose to not do a separate letter to your agent. In that case, be sure your agent gets this explanation too.

_____

_____

_____

_____

_____

_____

AFTER-DEATH WISHES

Initial those that apply. Leave blank if you do not agree.

Organ and tissue donation:

_____I wish to donate any and all of my organs and tissues.
_____I wish to donate only the organs or tissues listed here:_____
_____

Autopsy:

_____ My Agent is authorized to allow or request an autopsy.

Disposition of Remains:

_____ My Agent is authorized to direct the disposition of my remains.
_____ I have left specific after-death instructions which may be found at or in:
_____.

Agent Authorization:

_____ My Agent may override these after death wishes, including my written instructions, for demonstrated good reason.

SIGNATURE: Date: _____20_____
Sign here_____
Print your name here_____

(In order for this form to be complete and effective, it must be notarized or witnessed (usually by two persons), as required by the laws of the state in which you reside. For more information, see Finalization.)

Instructions

finalexodus.org/advance-directive-form/instructions-for-the-advance-health-care-directive-form/

Advance Directive (Living Will with Durable Power of Attorney for Health Care)

Please read the instructions before filling out this form.
This form emphasizes quality of life.

ADVANCE HEALTH CARE DIRECTIVE

(Living Will with Durable Power of Attorney for Health Care)

THE TERMS OF MY DIRECTIVE ARE ON PAGES 2-3

My Name is:_____ _____
Full Name Preferred First Name

My Agent (Surrogate or Proxy) is: _____

Agent's Phone Numbers:_____
Cell Home Work

Address:_____

My Alternate Agents are: (If the designated agent is unwilling or unable to serve)
(Optional)
1st Alternate: Name: _____
Phone Numbers:_____
Address: _____

2nd Alternate: Name: _____
Phone Numbers: _____
Address: _____

My Primary Physician is :
Dr. _____
Phone:_____
Address:_____

THE KEY TERMS OF MY DIRECTIVE ARE ON PAGE 2
Date and Signature are on page 3

Page 1 InstructionsPage 2 InstructionsPage 3 Instructions

INTRODUCTION

There are only three requirements for an effective Advance Health Care Directive in most states. It must be :

1. signed
2. dated
3. notarized or witnessed

Otherwise, you can put down what you want. For requirements in various states see **Finalization**.

Your Advance Health Care Directive should name someone who can make medical decisions for you when you are unable to do so. This person is called your **agent**, or sometimes your **surrogate** or **proxy**. As noted in THINK, this person must be carefully chosen, after you've discussed your wishes with her or him (and the alternate agent if you name one).

This form does not mention DNR – Do Not Resuscitate. Why? DNRs are designed to be used by patients who have had a serious health episode, and may have another. Most importantly, there can be times where resuscitation would be in order because it is not caused by a current medical condition. For example, if resuscitation is necessary because you choked on food.

In California and some other states, there is a special pink form called a Physician Orders for Life-Sustaining Treatment (POLST)There are various names for this form depending on your state. It is also known as Medical Orders for Life-Sustaining Treatment (MOLST), Medical Orders on Scope of Treatment (MOST), Physician's Orders on Scope of Treatment (POST) or Transportable Physician Orders for Patient Preferences (TPOPP) which your physician signs. People often put the POLST on their refrigerator where medics can see it. If one has a fully executed DNR or POLST order one can buy wearable jewelry from state-approved vendors.

Instructions for PAGE 1 of the Advance Health Care Directive Form . There is also an online Fillable Form)

Please read the instructions before filling out this form.
This form emphasizes quality of life.

ADVANCE HEALTH CARE DIRECTIVE
(Living Will with Durable Power of Attorney for Health Care)

THE TERMS OF MY DIRECTIVE ARE ON PAGES 2-3

My Name is:_____ _____
Full Name Preferred First Name

My Agent (Surrogate or Proxy) is: _____

Agent's Phone Numbers:_____
Cell Home Work

Address:_____

My Alternate Agents are: (If the designated agent is unwilling or unable to serve)
(Optional)
1st Alternate: Name: _____
Phone Numbers:_____
Address: _____

2nd Alternate: Name: _____
Phone Numbers: _____
Address: _____

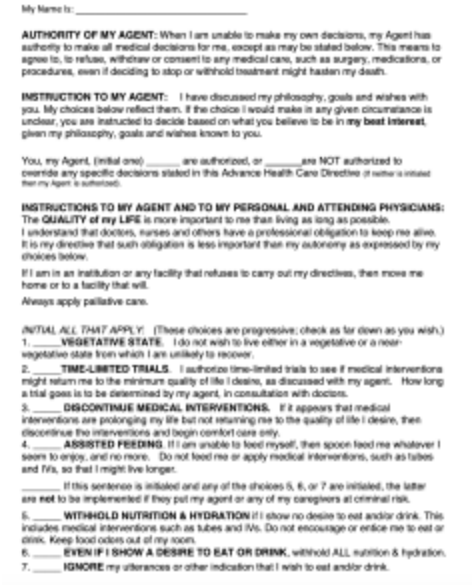
My Primary Physician is :
Dr. _____
Phone:_____
Address:_____

THE KEY TERMS OF MY DIRECTIVE ARE ON PAGE 2
Date and Signature are on page 3

Here you put down the names, phone numbers and addresses of your Agent, your Alternate Agents, and your primary care physician. The Alternate Agents have authority only if your Primary Agent is unwilling or unable to serve.

Go to the top of this page and to click to page 2 of the instructions.

Instructions for PAGE 2 of the Advance Health Care Directive Form



My Name Is: _____

AUTHORITY OF MY AGENT: When I am unable to make my own decisions, my Agent has authority to make all medical decisions for me, except as may be stated below. This means to agree to, to refuse, withdraw or consent to any medical care, such as surgery, medications, or procedures, even if deciding to stop or withhold treatment might hasten my death.

INSTRUCTION TO MY AGENT: I have discussed my philosophy, goals and wishes with you. My choices below reflect them. If the choice I would make in any given circumstance is unclear, you are instructed to decide based on what you believe to be in **my best interest**, given my philosophy, goals and wishes known to you.

You, my Agent, (initial one) _____ are authorized, or _____are NOT authorized to override any specific decisions stated in this Advance Health Care Directive (if neither is initialed then my Agent is authorized).

INSTRUCTIONS TO MY AGENT AND TO MY PERSONAL AND ATTENDING PHYSICIANS:
The **QUALITY of my LIFE** is more important to me than living as long as possible.
I understand that doctors, nurses and others have a professional obligation to keep me alive. It is my directive that such obligation is less important than my autonomy as expressed by my choices below.

If I am in an institution or any facility that refuses to carry out my directives, then move me home or to a facility that will.

Always apply palliative care.

INITIAL ALL THAT APPLY. (Those choices are progressive; check as far down as you wish.)
1. ____**VEGETATIVE STATE.** I do not wish to live either in a vegetative or a near-vegetative state from which I am unlikely to recover.
2. ____**TIME-LIMITED TRIALS.** I authorize time-limited trials to see if medical interventions might return me to the minimum quality of life I desire, as discussed with my agent. How long a trial goes is to be determined by my agent, in consultation with doctors.
3. ____ **DISCONTINUE MEDICAL INTERVENTIONS.** If it appears that medical interventions are prolonging my life but not returning me to the quality of life I desire, then discontinue the interventions and begin comfort care only.
4. ____ **ASSISTED FEEDING.** If I am unable to feed myself, then spoon feed me whatever I seem to enjoy, and no more. Do not feed me or apply medical interventions, such as tubes and IVs, so that I might live longer.
____ If this sentence is initialed and any of the choices 5, 6, or 7 are initialed, the latter are **not** to be implemented if they put my agent or any of my caregivers at criminal risk.
5. ____ **WITHHOLD NUTRITION & HYDRATION** if I show no desire to eat and/or drink. This includes medical interventions such as tubes and IVs. Do not encourage or entice me to eat or drink. Keep food odors out of my room.
6. ____ **EVEN IF I SHOW A DESIRE TO EAT OR DRINK**, withhold ALL nutrition & hydration.
7. ____ **IGNORE** my utterances or other indication that I wish to eat and/or drink.

AUTHORITY OF MY AGENT.Technically this a durable power of attorney for health care. This meets the legal requirement for your agent to speak for you when you can't speak for yourself. The authority is very broad.
INSTRUCTIONS TO MY AGENT. It says you've discussed your wishes with your Agent and ideally have translated these discussions into a Letter to your Agent. It makes clear that the Agent is to do what **you** would want, not what the Agent would want for herself or himself. The paragraph gives you an option; you may authorize your Agent to override your wishes as stated in the directive. This issue is really how much do you trust your agent? And, don't forget, while you are still able to think for yourself, you can always seek advice from your agent or from anyone you trust. Indeed, this is often a good idea.

INSTRUCTIONS TO MY AGENT AND TO MY PERSONAL AND ATTENDING PHYSICIANS.

Because you have lost your mental capacity to make decisions yourself, here is where you direct both your agent and your physicians as to what you expect of them. The first paragraph makes it clear that physicians' obligation to save life must be subordinate to your desires, which may be to shorten your life.

The first of the next two lines directs that if the institution where you might be living won't comply with your wishes, you are to be moved to another that will, or to home and the second line requests palliative care at all times.

Next, there are seven choices you may select by initialing. The choices are based on the **quality of life** you wish and not on a particular medical procedure. They are built around the concept that, for the days or months you have left, the **quality of your life** is more important than is living longer or for as long possible. The choices are progressive. That means each is more aggressive than the last. Thus there should be no gaps in your selections.

1. The first choice is to avoid living in a vegetative or near-vegetative condition from which you are unlikely to recover. A vegetative state is a state or condition in which a person is unable to communicate or respond to stimuli despite at times giving the appearance of wakefulness.

2. Next, you may choose time-limited trials of treatments to see if you can get back to a quality of life that is acceptable to you. What that quality of life is, and how long the trials are to last, are not stated. Indeed nowhere does this form say what that quality is, but you may enter it on page 3, or in an addendum you reference on page 3. The entire form assumes that you have discussed with your agent at some length what the term "quality of life" means to you. Moreover, your view of what is an acceptable quality of life may change, broaden or narrow, as your condition progresses. Hopefully you will have been able from time to time to discuss the **quality of life** you desire or want to avoid with your agent, before you become incapacitated. As to the length of a time trial, your agent needs to decide that in consultation with your doctors.

3. If medical interventions do not achieve the quality of life that you wish, then you direct that the interventions be stopped and that palliative care (comfort care) be administered until you die.

The remaining four choices move you into the arena of Stopping Eating and Drinking (SED). Before you lost your mental capacity, you may have considered Voluntarily Stopping Eating and Drinking (VSED), but failed to, or chose not to, institute it on your own. SED is not starvation but is dying because of dehydration. Death in this manner occurs without pain, assuming minimal medical care.

If you make any of these choices, they apply whether or not you have dementia. If you are concerned about possible dementia, you may want to augment this directive with a dementia supplement, where additional directions can be given. This website does not have such a supplement. To see some, go to Dementia Supplements under Resources/Other Advance Directives.

4. The fourth choice allows assisted feeding when you are unable to feed or drink yourself, but it prevents you from being kept alive by feeding you intravenously or through tubes.

There can be two levels of response to your desire to be fed or to drink. These are described in chapter 8 in the book *Stopping Eating and Drinking*, by Quill, et al (2021, University of Oxford Press), especially page 167. The first, called Comfort Feeding Only (CFO) is to give you as much hydration and nutrition as you desire. The second, called Minimum Comfort Feeding Only (MCFO) is to stop feeding you as soon as your minimum desire is met. The latter is more likely to move you toward death by SED. This advance directive form does not make the distinction. If you wish MCFO, you can put it on page 3.

The unnumbered choice inserted between choices 4 and 5 allows you to choose from among the remaining choices without putting your agent and caregivers at risk. The reason for this is, your choice to exit early by SED may put your agent and caregivers at risk criminally in many states. For a more complete discussion see – VSED, and the book cited there, by Quill, et al.

5. The difference from # 4 is that you are showing no desire to eat or drink. You direct all others not to feed you or give you fluids, orally or otherwise. In addition, you are not to be enticed to eat or drink.

6. Making this choice is likely the most difficult one. It creates serious concerns. First, is it legal for your agent, your family, and your physicians to starve/dehydrate you until death? In a few states it probably is; in a few states it is clearly not. In most states the law is not clear. In all states one can expect most medical and elderly-care establishments to be opposed. For more information, read chapter 10, Legal Issues, in the VSED book cited above.

Moreover, this option is forcing a difficult decision upon many: your agent, your family and your physicians. It forces them to put aside their own feelings to carry out your wish; they may not go along because they find the action offensive and/or immoral. Make # 6 your choice only after consulting your agent and your family. Don't choose it if any family member or your agent is opposed; controversy and even legal action could well result.

If you make this choice, experts urge you to make a video clearly stating your wish, and to renew this advance directive every few years, to show clearly that it is still your intent. On page 3 make reference to the video (or that you are about to make one). Make sure your agent has the video, or knows where and how to find it.

7. The last choice, ignore my utterances or other indication that I want to eat, is to counter a few judicial decisions that such utterances amount to revocation of your advance directive (that is, your incapacitated utterances are allowed to override you wishes made when you had capacity). This is called a Ulysses clause or contract.

Go to the top of this page and to click to page 3 of the instructions.

Instructions for PAGE 3 of the Advance Health Care Directive Form

The **IN ADDITION** section can be left blank or used for anything you wish. You might want to put down the qualities of life you want or don't want, or the foods you like or you don't like, or whether you wish to die at home. Being at home at the end is important to many people, not just because of the familiar surroundings, but also because it is so much easier to have your family around you. Alternatively such things can be put down in a special letter of instruction to your Agent. Such a separate instruction is recommended by others, and is often a good idea, depending on your circumstances.

My Name is: _____

CONSERVATORSHIP/GUARDIANSHIP: If a conservatorship/guardianship of my person needs to be appointed for me by a court, I nominate the agent designated in this form.

IN ADDITION: Optional.
See the instructions for possibilities. A Letter to My Agent is encouraged.
The following lines are for you to make additions or changes to your choices above. Also, if you choose one or more options above, 1, 2, 3, 4, 5, 6 and/or 7 (page 2), you may wish to state here what a minimum quality of life means to you, especially if you choose to not do a separate letter to your agent. In that case, be sure your agent gets this explanation too.

_____
_____
_____
_____
_____
_____

AFTER-DEATH WISHES
Initial those that apply. Leave blank if you do not agree.

Organ and tissue donation:
_____I wish to donate any and all of my organs and tissues.
_____I wish to donate only the organs or tissues listed here:_____
_____

Autopsy:
_____My Agent is authorized to allow or request an autopsy.

Disposition of Remains:
_____My Agent is authorized to direct the disposition of my remains.
_____I have left specific after-death instructions which may be found at or in:
_____

Agent Authorization:
_____My Agent may override these after death wishes, including my written instructions, for demonstrated good reason.

SIGNATURE: Date: _____20_____

Sign here_____

Print your name here_____

(In order for this form to be complete and effective, it must be notarized or witnessed (usually by two persons), as required by the laws of the state in which you reside. For more information, see Finalization.)

Also in the **IN ADDITION** section, you can restrict, add to, or otherwise change anything you've chosen on page 2. Also, as already noted, you can put down that minimum quality of life you wish to have, or the life you don't want. If these wishes can't be achieved, then the options you've chosen in **1** through **7** kick in.

Note also that you may choose to cross out some portion of an option or a sentence. That's easier than writing out the change. But **if you do a cross out, be sure to initial it**. Further, if there is not enough space for what you want to write, use an extra page. **Be sure to mention the extra page, and be sure the extra page references the particular place in your directive it is linked to and is signed and dated the same day as your directive.**

In the **AFTER-DEATH WISHES** section, you may donate your organs, authorize your agent to have an autopsy done, direct the disposition of your remains and authorize your agent to override your after-death wishes if there is a good reason to do so.

In the **SIGNATURE section,** you date and sign. But, do **NOT** do so until you have a notary or two witnesses before you, as your state may require. If you have both witnesses and a notary, sign before your witnesses. Any notary can do the acknowledgement needed. If you choose witnesses, a few types of people are restricted from being a witness. For more detail and for the signature pages for California see Finalization .

Click here to fill out the advance directive form online.