SUPPLEMENTAL ADVANCE DIRECTIVE FOR DEMENTIA CARE

This Supplemental Advance Directive is made by:

Name:

_____

Address:

_____

_____

I make this Supplemental Advance Directive for Dementia Care to inform my health care providers, loved ones, and health care surrogate of my treatment instructions in the event I lack capacity to give instructions myself. I am fully competent at this time. I have a separate, general advance directive in place. I ask that my general advance directive be maintained in my patient chart and applied according to its terms and that it be supplemented by this Advance Directive for Dementia Care.

I have also completed a legal form to appoint a health care surrogate and trust my surrogate to demand that my general advance directive be enforced in circumstances where it applies and this Supplemental Advance Directive for Dementia Care be enforced in the circumstances where it applies.

This Supplemental Advance Directive for Dementia Care should be applied when my dementia has progressed to the point at which, in the opinion of my health care surrogate, I do not recognize my family members, loved ones, and friends; I cannot remember their names; or I am not able to communicate well enough to make clear whether I recognize my friends and loved ones or remember

their names. I will call this "My Chosen End Point." I would wish to die quickly and peacefully under any of those circumstances.

At My Chosen End Point, I wish to receive the best available palliative and hospice care and refuse any medical treatment that would serve only to postpone my death, including, for example, vaccines, antibiotics, or other antimicrobial drugs, antiarrythmics, cardiopulmonary resuscitation, blood transfusions, or any artificial or mechanical means of life support. I do not wish to extend my life or prolong the dying process.

At My Chosen End Point, I wish to be allowed to die by VSED, or the voluntary stopping of eating and drinking. I do not want to be encouraged, persuaded, or forced to eat or drink. I do not want food or fluid to be held near my mouth to provoke me to open my mouth reflexively. I ask that the scent of food not be present in my room. I instruct that I not be hand fed or hydrated unless, in my surrogate's view, the lack of hand feeding and hydration appear to cause me physical or emotional distress and I affirmatively appear to seek to be hand fed or hydrated to relieve the distress. Any palliative or sedative medication should not be given orally, if possible. Moistening of my lips to keep them comfortable should not be considered a form of prohibited hydration.

I insist that nothing I do be deemed a revocation of this Advance Directive unless I revoke it in writing at a time when I have the mental capacity to make and revoke an advance directive. In my view, hand feeding and hydration are forms of medical treatment and require the patient's consent. Today, while I am competent, I insist that I be allowed to die naturally by not eating or drinking at My Chosen End Point. Given that any other advance directive signed while I am competent is honored after I lack capacity, even if I would die as a result, there is no reason for my instructions regarding hand feeding and hydration to be treated differently.

I intend that my health care surrogate alone be the one to determine whether I have reached My Chosen End Point. I authorize my health care surrogate to take any legal action necessary to enforce my choice to die from VSED if I have reached My Chosen End Point.

I ask that any health care institution providing treatment for me maintain my advance directives in my chart and document prominently that these advance directives are in place, as required by 42 U.S.C. § 1395cc and any applicable state

law. I ask that the health care institution's management review these documents and determine if the health care institution has any policy against the enforcement of their terms. If so, I ask that I be transferred to an appropriate health care institution that does not have such a policy.

Signed,

_____

Dated on _____, 20_____

We, the following witnesses, testify that we know the signer of this document and believe, based on our experience, the signer is competent to make the decisions reflected herein.

WITNESS NO. 1:

Address:

_____ _____

Signature

_____ _____

Name written legibly

WITNESS NO. 2:

Address:

_____ _____

Signature

_____ _____

Name written legibly

NOTARY FORM ON NEXT PAGE

STATE OF _____)

COUNTY OF _____)

The foregoing instrument was acknowledged before me this _____ day of _____, 202_____, by _____
(prospective patient's name, legibly written)
_____. The signer:

(notary must check one)

_____ is personally known to me, or

_____ or produced _____

_____ as identification.

_____
(Signature of Notary Public)

_____
(Print, Type, or Stamp Commissioned Name of Notary Public)