Advance Directives

HEALTH CARE POWER *of* ATTORNEY *and* LIVING WILL

PRINT YOUR NAME

DATE OF BIRTH

FOR INFORMATION CONTACT:
PATIENT RELATIONS AT 910 615-6120

"MY VOICE – *my choice.*"

MY WISH FOR:

- *The person I want to make care decisions for me when I can't.*
- *The kind of medical treatment I want or do not want.*
- *What I want my loved ones to know.*

CAPE FEAR VALLEY HEALTH

An Advance Directive For North Carolina
A Practical Form for All Adults

Introduction

This form allows you to express your wishes for future health care and to guide decisions about that care. It does not address financial decisions. Although there is no legal requirement for you to have an advance directive, completing this form may help you to receive the health care you desire.

If you are 18 years old or older and are able to make and communicate health care decisions, you may use this form.

This form has three parts. You may complete Part A only, or Part B only, or both Parts A and B. To make this advance directive legally effective, you must complete Part C of this form.

This form complies with North Carolina law (in NCGS § 32A-15 through 32A-27 and § 90-320 through 90-322).

Part A: Health Care Power of Attorney

1. What is a health care power of attorney? A health care power of attorney is a legal document in which you name another person, called a "health care agent," to make health care decisions for you when you are not able to make those decisions for yourself.

2. Who can be a health care agent? Any competent person who is at least 18 years old and who is not your paid health care provider may be your health care agent.

3. How should you choose your health care agent? You should choose your health care agent very carefully, because that person will have broad authority to make decisions about your health care. A good health care agent is someone who knows you well, is available to represent you when needed, and is willing to honor your wishes. It is very important to talk with your health care agent about your goals and wishes for your future health care, so that he or she will know what care you want.

4. What decisions can your health care agent make? Unless you limit the power of your health care agent in Section 2 of Part A of this form, your health care agent can make all health care decisions for you, including:

- starting or stopping life-prolonging measures
- decisions about mental health treatment
- choosing your doctors and facilities
- reviewing and sharing your medical information
- autopsies and disposition of your body after death

5. Can your health care agent donate your organs and tissues after your death? Yes, if you choose to give your health care agent this power on the form. To do this, you must initial the statement in Section 3 of Part A.

6. When will this health care power of attorney be effective? This document will become effective if your doctor determines that you have lost the ability to make your own health care decisions.

7. How can you revoke this health care power of attorney? If you are competent, you may revoke this health care power of attorney in any way that makes clear your desire to revoke it. For example, you may destroy this document, write "void" across this document, tell your doctor that you are revoking the document, or complete a new health care power of attorney.

8. Who makes health care decisions for me if I don't name a health care agent and I am not able to make my own decisions? If you do not have a health care agent, North Carolina law requires health care providers to look to the following individuals, in the order listed: legal guardian; an attorney-in-fact under a general power of attorney (POA) if that POA includes the right to make health care decisions; a husband or wife; a majority of your parents and adult children; a majority of your adult brothers and sisters; or an individual who has an established relationship with you, who is acting in good faith and who can convey your wishes. If there is no one, the law allows your doctor to make decisions for you as long as another doctor agrees with those decisions.

Part B: Living Will

1. What is a living will? In North Carolina, a living will lets you state your desire not to receive life-prolonging measures in any or all of the following situations:

- You have a condition that is incurable that will result in your death within a short period of time.
- You are unconscious, and your doctors are confident that you cannot regain consciousness.
- You have advanced dementia or other substantial and irreversible loss of mental function.

2. What are life-prolonging measures? Life-prolonging measures are medical treatments that would only serve to postpone death, including breathing machines, kidney dialysis, antibiotics, tube feeding (artificial nutrition and hydration), and similar forms of treatment.

3. Can life-prolonging measures be withheld or stopped without a living will? Yes, in certain circumstances. If you are able to express your wishes, you may refuse life-prolonging measures. If you are not able to express your wishes, then permission must be obtained from those individuals who are making decisions on your behalf.

4. What if you want to receive tube feeding (artificial nutrition and hydration)? You may express your wish to receive tube feeding in all circumstances. To do this, you must initial the statement in Section 2 of Part B.

5. How can you revoke this living will? You may revoke this living will by clearly stating or writing in any clear manner that you wish to do so. For example, you may destroy the document, write "void" across the document, tell your doctor that you are revoking the document, or complete a new living will.

Part C: Completing this Document

To make this advance directive legally effective, all three sections of Part C of the document must be completed.

1. Wait until two witnesses and a notary public are present, then sign and date the document.
2. Two witnesses must sign and date the document in Section 2 of Part C. These witnesses cannot be:
   - Related to you by blood or marriage,
   - Your heir, or a person named to receive a portion of your estate in your will,
   - Someone who has a claim against you or against your estate, or
   - Your doctor, other health care provider, or an employee of a hospital in which you are a patient, or an employee of the nursing home or adult care home where you live.
3. A notary public must witness these signatures and notarize the document in Section 3 of Part C.

What Should I Do With My Health Care Power of Attorney and Living Will?

Once you have signed the documents on the pages with the bar codes on them, and had them notarized, there are a few steps to take to be sure your wishes are carried out by your doctors, family and loved ones.

- **Make copies of the pages with the bar code on them.**
- **Mail or give a copy to your doctor.** If you mail it, be sure to include a cover letter with your address, date of birth, and phone number.
- **Discuss the Living Will with your doctor(s).** It is critical that you communicate with your doctor directly what your wishes are. Make sure you are both clear on what you want and that your wishes will be honored by the physician.
- **Give a copy of your document(s) to your health care agent, if you have one.** This is the person you named as your Health Care Power of Attorney, if you executed that document.
- **Give copies of your document(s) to family and loved ones.** You may also want to give a copy to your clergy.
- **Keep the original document(s) in a safe and easily-accessible place at all times.** You should make an extra copy for yourself in case you lose your original or it is accidentally destroyed or damaged. Do not put these documents in a safety deposit box.
- **Label one copy "Hospital" and bring it with you if you are admitted to a hospital.** Give it to the hospital staff so they can put it in your chart. Your documents will become a part of your lifetime medical record when you are discharged. If, at a later date, you change your documents, make sure the hospital receives the updated documents.
- **Make a list of everyone to whom you gave a copy of your document(s).** If, at a later date, you change your documents, you will have a list of who needs updated documents.

Part A: Health Care Power of Attorney (Choosing a Health Care Agent)

If you do not wish to appoint a health care agent, strike through this entire part and initial here _____

My name is: _____ My birth date is:___/___/_____
(Please Print)

_____ _____ _____ _____
Street Address City State Zip code

_____ _____ _____ _____
Home Phone Work Phone Cell Phone email address

1. The person I choose as my health care agent is:

_____ _____ _____
First name Middle name Last name

_____ _____ _____ _____
Street Address City State Zip code

_____ _____ _____ _____
Home Phone Work Phone Cell Phone email address

If this person is unable or unwilling to serve as my health care agent, my next choice is:

_____ _____ _____
First name Middle name Last name

_____ _____ _____ _____
Street Address City State Zip code

_____ _____ _____ _____
Home Phone Work Phone Cell Phone email address

2. Special Instructions:
NOTE: In this section, you may include any special instructions you want your health care agent to follow, or any limitations you want to put on the decisions your health care agent can make, including decisions about tube feeding, other life-prolonging treatments, mental health treatments, autopsy, disposition of your body after death, and organ donation. If you need additional space, please use the back of this page.

If you do not have any special instructions for your health care agent, or any limitations you want to put on your agent's authority, please draw a line through this section.

_____

_____

3. Organ Donation:

_____ (initial) My health care agent may donate my organs or parts after my death.

(Please note: If you do not initial above, your health care agent will not be able to donate your organs or parts.)

Part B: Living Will

If you do not wish to prepare a living will, strike through this entire part and initial here. _____

My name is _____ My birth date is ____/____/____
(Please print)

_____	_____	_____	_____
Street Address	City	State	Zip code

_____	_____	_____	_____
Home Phone	Work Phone	Cell Phone	email address

1. If I am unable to make or communicate health care decisions, I desire that my life not be prolonged by life-prolonging measures in the following situations (you may initial any or all of these choices):

_____ (initial) I have a condition that cannot be cured and that will result in my death within a relatively short period of time.

_____ (initial) I become unconscious and my doctors determine that, to a high degree of medical certainty, I will never regain my consciousness.

_____ (initial) I suffer from advanced dementia or any other condition which results in the substantial loss of my ability to think, and my doctors determine that, to a high degree of medical certainty, this is not going to get better.

_____ **(initial) Even though I do not want my life prolonged by other life-prolonging measures in the situations I have initialed in section 1 above, I DO want to receive tube feeding in those situations** (initial here **only** if you **DO** want tube feeding in those situations).

1 wish to be made as comfortable as possible. I want my health care providers to keep me as clean, comfortable, and free of pain as possible, even though this care may hasten my death.

My health care providers may rely on this living will to withhold or discontinue life-prolonging measures in the situations I have initialed above.

If I have appointed a health care agent in Part A of this advance directive or a similar document, and that health care agent gives instructions that differ from the desires expressed in this living will, then:
(NOTE: initial **ONLY ON**E of the two choices below):

___ (initial) **Follow this living will.** My health care agent cannot make decisions that are different from what I have stated in this living will.

___ (initial) **Follow health care agent:** My health care agent has the authority to make decisions that are different from what I have indicated in this living will.

Part C: Completing this Document
(wait until two witnesses and a notary public are present before you sign!)

1. Your Signature

I am mentally alert and competent, and I am fully informed about the contents of this document.

Date: _____

Signature: _____

2. Signatures of Witnesses

I hereby state that the person named above, _____, being of sound mind, signed (or directed another to sign on the person's behalf) the foregoing document in my presence. I am not related to the person by blood or marriage, and I would not be entitled to any portion of the estate of the person under any existing will or codicil of the person or as an heir under the law, if the person died on this date without a will. I am not the person's attending physician. I am not a licensed health care provider or mental health treatment provider who is (1) an employee of the person's attending physician or mental health treatment provider, (2) an employee of the health facility in which the person is a patient, or (3) an employee of a nursing home or any adult care home where the person resides. I do not have any claim against the person or the estate of the person.

Date:_____ Signature of Witness:_____

Date:_____ Signature of Witness:_____

3. Notarization

_____COUNTY, _____STATE

Sworn to (or affirmed) and subscribed before me this day by

_____ (type/print name of signer)

_____ (type/print name of witness)

_____ (type/print name of witness)

Date:_____ _____

Signature of Notary Public

(Official Seal) _____ Notary Public

Printed or typed name

My commission expires: _____

To My Health Care Agent, From _____

I have completed a Health Care Power of Attorney document, and in that document, I have appointed you as my Health Care Agent. I want you to have the following important information about your duties as my health care agent:

1. Your role as my Health Care Agent is to make health care choices for me if I am no longer able to make those decisions for myself. My physician will determine when I have lost the ability to make health care decisions.

2. I will provide you a copy of the Health Care Power of Attorney document that appoints you as my Health Care Agent. If I have included in that document any special instructions for you or any limitations on the decisions you can make for me, I will tell you about those. You should follow those instructions and respect those limitations, even if they are different from the choices you might make for yourself.

3. As my Health Care Agent, you will have the authority to make many health care decisions on my behalf. This authority includes the ability to:

- Access my medical information,
- Make decisions about who provides my medical care,
- Admit me to and discharge me from a health care facility (including a mental health facility), assisted living facility or nursing home.
- Withhold or withdraw any life-prolonging measures,
- Authorize an autopsy,
- Direct the disposition of my body after death, and
- Give consent for any tests, procedures or surgeries.

If I do not want you to have the authority for any of these duties, I have stated so in the health care power of attorney document.

4. I am relying on you to make health care choices on my behalf if I am no longer able to do so. I ask that you make treatment choices for me based on my goals and desires about what kind of care I should receive. It is very important, therefore, that we take time to discuss my desires, goals, and hopes for medical treatment so that you will know what kind of care I want.

5. If I need medical care and am unable to make my own treatment decisions, please discuss my medical condition and treatment options with my physicians and other health care providers. Please ask them for any medical information you need, and ask them to explain anything you don't understand. The information they provide will help you to make informed decisions about what treatment I would prefer.

6. If, at some later time, you decide that you can no longer serve as my health care agent, please let me know. That will allow me to appoint someone else as my health care agent Likewise, if I decide at some future time to appoint another person as my health care agent, I promise to let you know. Either decision will release you from any further responsibilities as my health care agent.

I accept appointment as your health care agent

_____
Health Care Agent Signature

_____
Date