Advance Directive

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.

Frequently Asked Questions

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 the care you want.

4. 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.

5. 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.

6. 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.

7. What if you want to receive tube feeding (artificial nutrition and hydration)? You may express your wish to receive tube feeding in certain circumstances. To do this, select the options you desire in Section 6(A).

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

Once you have signed the document in the presence of a notary, 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 document(s) will become a part of your lifetime medical record. If, at a later date, you change your document(s), make sure the hospital receives the updated document(s).
- **Make a list of everyone to whom you gave a copy of your document(s).** If, at a later date, you change your document(s), you will have a list of who needs updated document(s).

Health Care Power of Attorney

1. Designation of a Health Care Agent (Please Print)

My name is: _____ My date of birth is:_____/_____/_____

My address is:_____
Street Address City State Zip code

_____ _____ _____
Home Phone Work Phone Cell Phone

I choose the following person to serve as my health care agent to make health care decisions for me as authorized in this document. The document will become effective when my doctor determines that I have lost the ability to make or communicate my own health care decisions:

Name: _____ Relationship:_____

Home address:_____
Street Address City State Zip code

_____ _____ _____
Home Phone Work Phone Cell Phone

Should the person named above be unable or unwilling to serve as my health care agent, I choose the following person to act as my health care agent instead:

Name: _____ Relationship:_____

Home address:_____
Street Address City State Zip code

_____ _____ _____
Home Phone Work Phone Cell Phone

2. General Statement of Authority Granted

Subject to any restrictions I otherwise provide in this document, I grant to my health care agent full power and authority to make and carry out all health care decisions for me regarding my health care, including, but not limited to, the power and authority to:

A. Review and share any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

B. Choose my health care providers.

C. Choose my health care facility and conset to my admission. A health care facility could include a hospital, nursing or convalescent home, hospice, long-term care facility, or other health care facility.

D. Consent to my admission to a facility for the care or treatment of mental illness. I may complete Section 3 of this document or a separate Advance Instruction for Mental Health Treatment to give further instruction or restriction regarding my mental health treatment. If I do not complete Section 3, and I do not complete a separate Advance Instruction for Mental Health Treatment, my health care agent will have broad authority to consent to my care and treatment of mental illness.

E. Consent to the administration of medications for mental health treatment and electroconvulsive treatment (ECT) commonly referred to as "shock treatment." I may complete Section 3 of this document or a separate Advance Instruction for Mental Health Treatment to give further instruction or restriction regarding my mental health treatment. If I do not complete Section 3, and I do not complete a separate Advance Instruction for Mental Health Treatment, my health care agent will have broad authority to consent to the administration of medications for my mental health treatment.

F. Give consent for, withdraw consent for, or withhold consent for all diagnostic and treatment procedures ordered by or under the authorization of a health care provider. This authorization specifically includes the power to consent to measures for relief of pain.

G. Authorize the starting or stopping of life-prolonging measures. I may complete Section 6 of this document containing my Advance Directive. If I complete Section 6, my health care agent should follow any instructions or limitations I give regarding life-prolonging measures. If I do not complete Section 6, my health care agent will have broad authority to choose when to start or stop life-prolonging measures.

H. Authorize an autopsy or direct disposition of my remains, subject to any instructions or limitations contained in Section 4 of this document.

I. Take any lawful actions that may be necessary to carry out these decisions.

3. Special Provisions and Limitations

Only complete this Section 3 if you wish to limit the scope of powers given to your health care agent as stated above. If none of the following are initialed, there will be no special limitations on your agent's authority.

NOTE: DO NOT initial unless you insert a limitation.

A. _____ (**Initial**) In exercising the authority to make health care decisions, including mental health care decisions on my behalf, the authority of my health care agent is subject to the following special provisions:

_____

_____

B. _____ (**Initial**) In exercising the authority to make decisions regarding autopsy and disposition of remains on my behalf, the authority of my health care agent is subject to the following special provisions and limitations:

_____

_____

4. Guardianship Provision

If it becomes necessary for a court to appoint a guardian of my person, I nominate the persons designated in Section 1, in the order named, to be the guardian of my person, to serve without bond or security. The guardian shall act consistently with G.S. 35A-1201(a)(5). *(Only initial here if you would like to nominate your health care agent to serve as guardian; otherwise, leave blank)* _____

5. Reliance on Health Care Agent

A. Any person who relies in good faith on the authority of my health care agent will not be liable for any actions or omissions made based on my health care agent's authority.

B. Only my health care agent can exercise the powers granted in this document. Once this document is effective, my health care agent's signature or actions taken consistently with this document may be accepted as if I fully authorized them and were personally present, competent, and acting on my own behalf. Any action taken by my healthcare agent consistent with this document and done in good faith will bind me, my estate, my heirs, my successors, assigns, and personal representatives. My health care agent's authority granted in this document is superior to any authority of my family, relatives, friends or others.

6. Advance Directive Regarding a Natural Death

You are only required to complete this section if you would like to give specific instructions regarding life-prolonging measures that might be available to you. If you choose not to complete this Section 6, your health care agent will have the ability to determine when life-prolonging measures should be withheld or withdrawn and will have the authority to withhold artificial nutrition and hydration.

A. With respect to life-prolonging measures, if my attending physician determines that I lack capacity to make or communicate health care decisions and:

I. I have an incurable or irreversible condition that will result in my death within a relatively short period of time, I direct the following (**Initial ONE blank only**):

_____ (**Initial**)

Directive to Withhold or Withdraw Treatment: I DO NOT want my life to be prolonged and I direct that life-prolonging measures MUST be withheld or discontinued notwithstanding any directions of my health care agent to the contrary.

However, I DO want to receive artificial nutrition and hydration (**You must initial here if you want to receive artificial nutrition or hydration. Otherwise, leave blank.**) _____

_____ (**Initial**)

Directive for Maximum Treatment: I DO NOT authorize my health care agent to withdraw, withhold, or discontinue any life-prolonging measures. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of such procedures.

II. I am unconscious and, to a high degree of medical certainty, will never regain my consciousness, I direct the following (**Initial ONE blank only**):

_____ (**Initial**)

Directive to Withhold or Withdraw Treatment: I DO NOT want my life to be prolonged and I direct that life-prolonging measures MUST be withheld or discontinued notwithstanding any directions of my health care agent to the contrary.

However, I DO want to receive artificial nutrition and hydration (**You must initial here if you want to receive artificial nutrition or hydration. Otherwise, leave blank.**) _____

_____ (**Initial**)

Directive for Maximum Treatment: I DO NOT authorize my health care agent to withdraw, withhold, or discontinue any life-prolonging measures. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of such procedures.

III. I suffer from advanced dementia or any other condition resulting in the substantial loss of cognitive ability and that loss, to a high degree of medical certainty, is not reversible, I direct the following (**Initial ONE blank only**):

_____ (**Initial**) **Directive to Withhold or Withdraw Treatment**: I DO NOT want my life to be prolonged and I direct that life-prolonging measures MUST be withheld or discontinued notwithstanding any directions of my health care agent to the contrary.

However, I DO want to receive artificial nutrition and hydration (**You must initial here if you want to receive artificial nutrition and hydration. Otherwise, leave blank.**) _____

_____ (**Initial**) **Directive for Maximum Treatment**: I DO NOT authorize my health care agent to withdraw, withhold, or discontinue any life-prolonging measures. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of such procedures.

7. Organ Donation

If you would like for any or all of your organs to be made available for donation, please initial one of the options below. If you do not wish to donate any organs, please leave this section blank.

To the extent I have not already made arrangements during my lifetime that have not been revoked, my health care agent may exercise any right I may have to:

_____ (**Initial**) donate any needed organs or parts; or

_____ (**Initial**) donate only the following organs or parts: _____

_____ (**Initial**) donate my body for anatomical study if needed.

In exercising the authority to make donations, my health care agent is subject to the following special provisions and limitations:

_____

_____

_____

_____

STOP: DO NOT COMPLETE THIS PAGE WITHOUT A NOTARY PRESENT

I am mentally alert and competent. I am not under any duress, fraud, or undue influence. I am fully informed about the contents of this document. I understand that this document sets forth my wishes about future conditions under which life-prolonging measures may be withheld or discontinued.

Date: _____ Signature: _____

I hearby state that the person named above, _____, signed the document in my presence, and appears to be of sound mind and not under duress, fraud, or undue influence. I am not related to the principal by blood, marriage, or adoption and I would not be entitled to any portion of the estate of the principal under any existing will or codicil of the principal or as an heir under the Intestate Succession Act, if the principal died on this date without a will. I also state that I am not the principal's attending physician, nor a licensed health care provider or mental heath treatment provider who is (1) an employee of the principal's attending physician or mental health treatment provider, (2) an owner, operator, or employee of an owner or operator of the health facility in which the principal is a patient, or (3) an employee of a nursing home or any adult care home where the principal resides. I further state that I do not have any claim against the principal or the estate of the principal.

Date:_____ Signature of Witness:_____

Date:_____ Signature of Witness:_____

_____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: _____

THIS PAGE IS INTENTIONALLY LEFT BLANK

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 with 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 as laid out in Section 2 of that document, unless I have otherwise made limitations in the 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