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MEMORANDUM TO CLIENT REGARDING
ADVANCE HEALTH CARE DIRECTIVE

Please read the Advance Health Care Directive Explanation which accompanies this memo.

AGENT

ALTERNATIVE AGENT

Name: _____

Name: _____

Address: _____

Address: _____

Telephone: _____

Please complete this memo as follows:

Enter above the details of person(s) you wish to make Health Care decisions for you in the event of your becoming incapacitated.

PART I: Period during which Agent's authority is effective
Anatomical Gifts - Disposition of Organs, tissues or parts (Qualify if desired)
Power to direct disposition of remains
Arrangements for Funeral or Memorial Service
Authorization of Autopsy
Nomination of Conservator of Person
Expiration

- Select either A or B
- Select either A, B or C
- Select either A, B or C
- Initial if desired
- Select either A or B
- Enter details
- Enter date if so desired

PART II: End-of-Life Decisions
Relief from pain
Hydration and Nutrition
Additional Statement of Desires

- Select either A, B, C, D or E
- Initial if desired
- Initial if desired
- Complete if desired

PART III: INSTRUCTIONS FOR PERSONAL CARE
Independent Living

- Initial any of the statements you wish to have included

PART I

Please select one of the following and initial:

PERIOD DURING WHICH AGENT'S AUTHORITY IS EFFECTIVE.

- A. My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions. My agent's authority ceases to be effective when my primary physician determines that I am again able to make my own health care decisions.

Initials

- B. My agent's authority to make health care decisions for me takes effect immediately.

Initials

ANATOMICAL GIFTS

Disposition of Organs, tissues or parts.

- A. Upon my death, my agent may donate any organs, tissues, or parts.

Initials

- B. Upon my death, my agent may donate only the following organs, tissues or parts:

This gift shall be for the following purposes only:

Initials

- C. Upon my death, my agent may not donate any organs, tissues or parts.

Initials

Please select one of the following and initial:

POWER TO DIRECT DISPOSITION OF REMAINS

- A. My agent shall have the power and authority to direct the disposition of my remains according to his/her discretion.

Initials

- B. My agent shall have the power and authority to direct the disposition of my remains according to my desires as follows:

Initials

- C. My agent shall not have the power or authority to direct the disposition of my remains.

Initials

ARRANGEMENTS FOR FUNERAL OR MEMORIAL SERVICE (OPTIONAL)

My agent shall have the power and authority to arrange for my funeral or other memorial service.

Initials

Please select one of the following and initial:

AUTHORIZATION OF AUTOPSY

- A. My agent shall have the power and authority to authorize an autopsy.

Initials

- B. My agent shall not have the power or authority to authorize an autopsy.

Initials

NOMINATION OF CONSERVATOR OF PERSON

If a conservator of the person is to be appointed for me, I nominate the following individual to serve as conservator of the person:

_____ Agent authorized by this AHCD	Name: _____
_____ Other:	Address: _____

	Telephone: _____

EXPIRATION

Unless you choose to limit the duration of your Advance Health Care Directive, the Directive will be valid indefinitely. We recommend that you not limit the duration. However, if you choose to limit the duration (and enter an expiry date below), you will have to create a new Directive after the expiration date.

This advance health care directive expires on _____.

PART II
INSTRUCTIONS FOR HEALTH CARE

Please select one of the following and initial:

END-OF-LIFE DECISIONS

A. No Treatment Which Merely Prolongs Inevitable Death

I recognize that modern medical technology has made possible the artificial prolongation of my life beyond natural limits. I do not wish to artificially prolong the process of my dying if continued health care will not improve my prognosis for recovery or otherwise enable me to live a productive and/or enjoyable life. Therefore, I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued (1) if I am in an irreversible coma or persistent vegetative state; or (2) if I am terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death; or (3) under any other circumstances in which the burdens of the treatment outweigh the expected benefits. By "an irreversible coma," I mean a coma from which the treating physicians have reasonably concluded I will never regain consciousness. In making decisions about life-sustaining treatment under provision (3) above, I want my agent to consider the relief of suffering and quality of remaining life as well as the extent of the possible prolongation of my life.

Initials

B. Treat Unless in Irreversible Coma

I want to receive medical treatment that prolongs and sustains my life unless I am in an irreversible coma. By an "irreversible coma" I mean a coma from which the treating physician or physicians have reasonably concluded I will never regain consciousness. If I am in such an irreversible coma, I do not want to receive medical treatment that prolongs and sustains my life.

Initials

C. No Life-Sustaining Procedures if in Terminal Condition

If I am in a terminal condition, I do not want any life-sustaining procedures to be used to prolong my life. For purposes of this document, (1) "terminal condition" shall mean an incurable condition caused by injury, disease, or illness, which, regardless of the application of life-sustaining procedures, would, within reasonable medical judgment, produce death and in which the application of life-sustaining procedures serves only to postpone the moment of my death; and (2) "life-sustaining procedures" shall mean any medical procedure or intervention that utilizes mechanical or other artificial means to sustain, restore, or supplant a vital function which will serve only to artificially prolong the moment of my death. The term "life-sustaining procedures" shall not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain.

Initials

D. Treat to Allow Life as Long as Possible

I want to live as long as possible; therefore, I want to receive all medical treatment that will prolong and sustain my life within the limits of generally accepted health care standards. I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment.

Initials

E. No Statement of Desires

Initials

RELIEF FROM PAIN (OPTIONAL)

I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death. I wish to receive any other forms of palliative care that may ease my suffering.

Initials

HYDRATION AND NUTRITION (OPTIONAL)

I direct that when life-sustaining procedures or treatment are withheld or withdrawn, that hydration and nutrition also be withheld or withdrawn when they are the only means by which my life is being sustained unless necessary for my comfort or alleviation of pain.

Initials

ADDITIONAL STATEMENT OF DESIRES (OPTIONAL)

OTHER WISHES:

Initials

PART III

INSTRUCTIONS FOR PERSONAL CARE

INDEPENDENT LIVING

I wish to live in my home for as long as that is reasonably possible without endangering my physical or mental health and safety, and to receive whatever assistance from household employees or personal care givers as may be necessary to permit me to do so, *provided, however, that in the event my agent determines that appropriate household employees or personal care givers are not available without putting my financial position or physical or mental health or safety at risk, then I wish to live in the least restrictive and most home-like setting deemed appropriate by my agent. I further request that I live as near as possible to my primary residence in order that I may visit with friends and neighbors to the degree my agent believes that I will benefit from such relationships.*

I wish to return home as soon as reasonably possible after any hospitalization or transfer to convalescent care. If my agent determines that I am no longer able to live in my home, I wish that my agent consider alternatives to convalescent care which will permit me as much privacy and autonomy as possible, including such options as placing me in an assisted living facility or board and care facility.

THE LANGUAGE INCLUDED IN THE ABOVE PARAGRAPH IN ITALICS IS OPTIONAL. IF YOU WOULD LIKE TO INCLUDE THIS LANGUAGE, PLEASE INITIAL IN THE SPACE PROVIDED.

Initials

SOCIAL INTERACTION (OPTIONAL)

I wish to be encouraged to maintain my social relationships and to engage in social interaction even if I am no longer able to recognize my family and friends or to fully participate in social activities.

Initials

Please select and initial as desired.

RELIGIOUS OR SPIRITUAL ACTIVITY (OPTIONAL)

My involvement with _____ has been very important to me. I wish to maintain that involvement as long as possible, even if I no longer fully appreciate its significance. To that end, in accordance with my established beliefs and customary activities, my agent shall provide for the presence and involvement of clergy or other persons to attend to my spiritual needs and permit them access to me and shall arrange for my access to activities and publications, including books, tapes, and similar materials, associated with my spiritual involvement.

Initials

My agent shall not in any way impose his/her religious beliefs, or the religious beliefs of others, on me.

Initials

OUTDOOR ACTIVITIES (OPTIONAL)

I wish to spend significant time outdoors. If I can no longer travel, I wish my agent to arrange for trips to local parks and other areas where I may be outdoors in a natural setting.

Initials