HEALTH CARE ADVANCE DIRECTIVES… THE PATIENTS RIGHT TO DECIDE

Every competent adult has the right to make decision concerning his or her own health, including the right to choose or refuse medical treatment.

We as physicians are required to provide their patients with written information, such as pamphlet, concerning health care advance directives.

Please see attached copies of Living Will, Designation of Health Care Surrogate, and Questions About Health Care Advance Directives.

You can print your own copy in English & Spanish along with other forms (Donor Form, Wallet Card about Advance Directives) from this website. Ahca.myflorida.com

For these forms to be completed: your office staff can witness them, (they do not require a notary) give the original to the patient and make a copy for their charts and family members.

Please encourage each member to read the necessary information to make advanced directives instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions.

Please initial_____ Date:_____

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions:

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

o I have made such declaration.
o I have NOT made such a declaration.

Health Care Surrogate

o I have designated a Health Care Surrogate.
o I have NOT designated a Health Care Surrogate.

Durable Power of Attorney

o I have appointed a Durable Power of Attorney for Health Care decisions.
o I have NOT appointed a Durable Power of Attorney for Health Care decisions.

I have been provided information regarding the PATIENT SELF DETERMINATION ACT:

Print Full Name _____ Social Security Number _____

Signature _____ Date _____

Relationship of Patient Representative (If applicable): _____

YEARLY RECONFIRMATION

I acknowledge that this information remains accurate.

Signature of Patient or Patient Rep _____ Date _____ Signature of Patient or Patient Rep _____ Date _____

Signature of Patient of Patient Rep. _____ Date _____ Signature of Patient of Patient Rep. _____ Date _____

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Signature of Patient or Patient Rep: _____ Date: _____

Living Will

Declaration made this _____ day of _____, 2_____, I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____ (initial) I have a terminal condition,
Or _____(initial) I have an end-stage condition,
Or _____(initial) I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

I do_____, I do not _____ desire that nutrition and hydration (food and water) be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name:_____ Phone: _____
Street Address:_____
City:_____ State: _____ Zip Code: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration. Additional instruction (optional):

_____
_____
_____
_____

Signed: _____

Witness: _____
Street Address: _____
City:_____ State:_____
Phone: _____

Witness: _____
Street Address: _____
City:_____ State:_____
Phone: _____

At least one witness must not be a husband or wife or a blood relative of the principal.

Designation of Health Care Surrogate

Name: _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name:_____ Phone: _____

Street Address:_____

City:_____ State: _____ Zip Code: _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name:_____ Phone: _____

Street Address:_____

City:_____ State: _____ Zip Code: _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; or apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional instruction (optional):

_____
_____
_____
_____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name:_____ Phone: _____

Signature:_____ Date: _____

Witnesses: 1. _____

2. _____

At least one witness must not be a husband or wife or a blood relative of the principal.