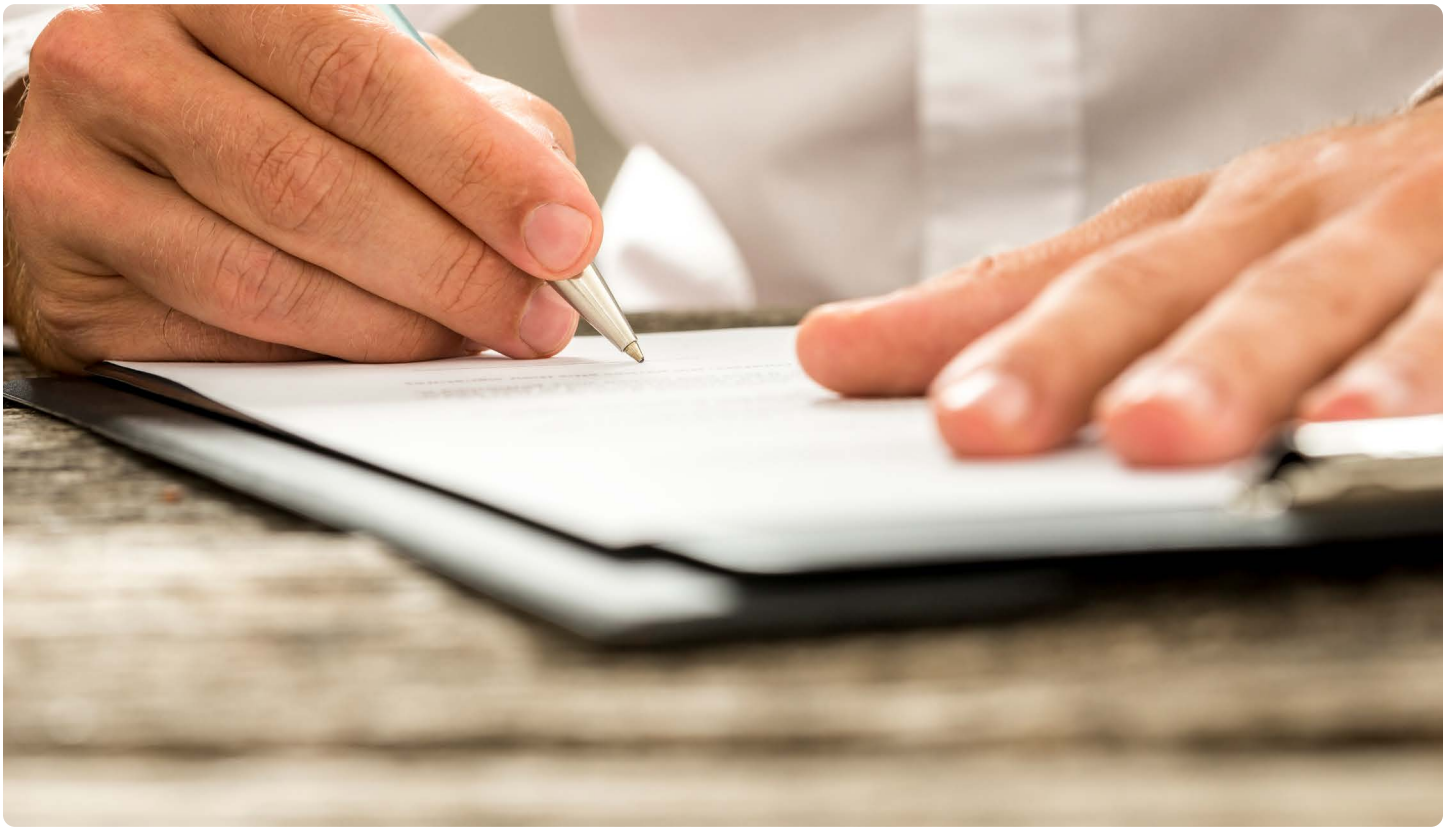


Taking Charge of Your Health Care

Health Care Advance Directive

MaineHealth

Health Care Advance Directive Form

An advance directive allows you to state your wishes about the health care you want to receive if you become too hurt or ill to communicate. It also allows you to choose someone to make decisions on your behalf. Anyone's health status can change suddenly, so even if you're healthy, it's still important to fill out an advance directive.

There are 2 parts to this form:

- Part A: Your Health Care Agent
- Part B: Your Wishes

Instructions for using the form:

1	You can fill out Part A, Part B, or both.
2	Sign and date the form on **page 7**. This form is not legally executed until it is signed. You must have 2 witnesses sign and date the form at the same time you sign it. Your agent **cannot** sign as a witness.
3	Give a copy of the signed form to your doctor to put in your medical record. Give a copy to the health care agent(s) you have chosen as well.

Talk with your family members, doctors, and others close to you about your wishes.

Be sure to let everyone know if you make changes or complete a new form. If you make changes, put your initials and date next to them.

You do not need a Notary Authorization in the state of Maine or New Hampshire. However, if you think you may use this form in a state other than Maine or New Hampshire, you may want to have it notarized.

If you need help or would like to learn more about advance directives:

- Visit mainehealth.org/advancedirective
- Contact your primary care provider's office to ask for help.
- Ask a trusted friend or loved one to review the form with you.

Part A: Your Health Care Agent

This part lets you choose someone to make health care decisions for you if you become too hurt or ill to speak for yourself. This person is called your **agent** — or medical power of attorney, health care proxy, or other terms that mean the same thing.

You should talk to your agent to make sure they understand your wishes and are willing to take on the responsibility.

Who can be your agent? You can choose any adult you trust to be your agent.

Who can NOT be your agent? A person who is the owner, administrator, or employee of a nursing home or residential long-term care facility where you are receiving care, unless that person is your relative.

Which decisions could my agent make?

If you do not fill out any of Part B on the form, your agent could make any health decision they believe would be consistent with your values. For example, they would be able to decide:

- Whether or not to have food or fluids given through tubes or through an IV;
- Which tests and treatments you would be willing to receive, including surgery and medication;
- Whether or not to try to restart your heart;
- Your doctors, other health care professionals, hospitals, clinics, and nursing homes.

How your agent must make decisions if needed:

If you make choices in Part B, your agent must make decisions based on those choices. If your agent does not know what you want, the agent must make decisions by considering which choices you would make based on your values, preferences, and conversations that you've had.

Who can see your health care information:

If your agent needs to act on your behalf, they will have access to your medical records and can consent to giving your medical information to others. The state and federal privacy laws let your agent see all of your health information so that they can make the right decision for you.

Print your name, address and birth date.

My name (please print): _____

My address: _____

My birth date: _____

Name of your Health Care Agent

This is the person I want to make health-related decisions for me if I am unable:

My agent's name (please print): _____

My agent's title or relationship to me: _____

My agent's address: _____

My agent's preferred phone: ( ) _____ Secondary phone: ( ) _____

We recommend listing a second person as well. This person would make decisions if your agent was not willing, reasonably available, or able to make decisions for you.

Second choice name (please print): _____

Relationship to me: _____

Address: _____

My agent's preferred phone: ( ) _____ Secondary phone: ( ) _____

If my second choice agent is not willing, reasonably available or able to make decisions for me, I name the following person to be my third choice agent:

Third choice name (please print): _____

Relationship to me: _____

Address: _____

My agent's preferred phone: ( ) _____ Secondary phone: ( ) _____

Your agent's power:

When your agent can start making decisions for you: (Check only 1 box.)

☐ My agent can make decisions only when a health care provider or a judge decides that I am too sick to make my own health care decisions.

OR

☐ My agent can start making health care decisions for me right away, but this does not mean I have given up the right to make my own decisions if I am still able and willing to make my own decisions.

Note: People come from different backgrounds and cultures and may want someone else to make health care decisions for them, even if they can still make their own decisions.

Canceling or changing your agent:

You may end your agent's right to make decisions by telling your doctor or putting your decision in writing and attaching it to this form. If you want to name a new agent, you must put it in writing and sign it in front of two witnesses who must also sign their names.

Important



Next, if you want to give instructions about your health care wishes, fill out Part B (pages 5 and 6).

- You may fill out all of Part B or only the parts you want. You can cross out or add anything you wish.
- If you do not fill out anything in Part B of this form, your agent will be asked to make health care decisions that they believe you would want.

If you do not want to fill out any of Part B, you can go to page 7 and sign.

Part B: Your Wishes

This part of the form allows you to give instructions to your health care agent, doctors, and loved ones about your wishes, such as when you are near death or will never be conscious again (sometimes called a persistent vegetative state).



Note: You may cross out or add words. It is best if you put your initials and date next to any changes you make so everyone knows the changes were your decision.

Check one of the two boxes below to show your choice about treatment that would keep you alive.

☐ Choice **NOT** to receive life-sustaining treatment

I do **NOT** want to receive life-sustaining treatment if my physician decides that any of the following are true:

- I have an illness that will not get better, cannot be cured, and will result in my death quite soon (sometimes called a terminal condition).

OR

- My physician and a second physician decide that I am in the late stage of Alzheimer's disease or other severe dementia.

OR

- I am no longer aware (unconscious) and it is very likely that I will never be conscious again (sometimes called a persistent vegetative state).

☐ Choice to receive **ALL** appropriate life-sustaining treatment

- I want to receive all appropriate life-sustaining treatment as long as possible within the limits of generally accepted health care standards, even if my condition is terminal or it is very likely that I will never be conscious again (sometimes called a persistent vegetative state).

OR

- I want to receive all appropriate life-sustaining treatment as long as possible within the limits of generally accepted health care standards, even if my physician and second physician decide that I am in the late stage of Alzheimer's disease or other severe dementia.

Relief from pain:

You may check the box or fill in the space below to show your choice about relief of pain or discomfort.

☐ I want to receive treatment for pain relief or discomfort at all times, even if it makes me drowsy, unconscious or unable to do other things.

These are my wishes about relief of pain and discomfort:

Other instructions:

You may give more instructions or add any other treatment choices in the space below. You may include instructions for funeral, burial, or wishes for remembrance.

Custody and control of body (optional):

Fill out this part only if you wish to give special instructions about your body after your death.

☐ I choose _____ to have custody and control of my body after I die with the right to decide everything about my funeral and burial.

If you plan to die at home, talk with your physician and funeral director about your plans. When you die, your family or agent should call your physician and the funeral home you have chosen. The funeral home staff will pick up your body from your home.

Signing the Form

You must sign and date on this page. You must have 2 adult witnesses sign and date the form at the same time you sign. Your agent cannot sign as a witness.

☐ Please check this box if you did not fill out any of Part B: Your Wishes.

You sign and date the form here:

Your signature: _____ Your Address: _____

Print your name: _____ _____

Date: _____ _____

First witness sign and date the form here:

Signature: _____ First Witness Address: _____

Print name: _____ _____

Date: _____ _____

Second witness sign and date the form here:

Signature: _____ Second Witness Address: _____

Print name: _____ _____

Date: _____ _____

Notary Acknowledgment (optional):

Then personally appeared the above named _____ known to me or who presented satisfactory evidence of his/her identity, and acknowledged this Advance Directive as their free act and deed before me.

Notary Signature: _____ Date: _____

Printed name: _____ Notary Public State of: _____ Commission Exp.: _____

Canceling or changing the form:

You may cancel any other part of this form, or change your instructions in the other parts of this form, while you are still able to make those decisions. It is best to do so by (1) writing on this form, or (2) writing on another piece of paper and attaching it to this form, or (3) completing a new form. You should put your initials and date next to any changes.

DO-NOT-RESUSCITATE (DNR) DIRECTIVE

This section is optional. If you do not want ambulance crews to revive you if your heart or breathing stops, you and your physician (or nurse practitioner or physician assistant) must complete and sign this form.

FOR PATIENT TO COMPLETE after consultation with his or her health care provider:

In the event that my heart or breathing stops and I am unable to speak for myself, I, _____ (printed name) direct that no efforts be taken to restart my heart or breathing and that Emergency Medical Services (ambulance crews) if notified, honor my directive. I have come to this decision after considering my condition and prognosis and the potential risks, burdens and benefits of refusing efforts to restart my heart or breathing.

I understand that I may change my mind at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry, such as MedicAlert. I will also tell my physician (or nurse practitioner or physician assistant) and other caregivers if I change my mind.

I understand that this form is not valid until my physician (or nurse practitioner or physician assistant) and I have signed it.

I understand that in a hospital, nursing home, hospice or home health setting, federal law requires that my physician must include a specific DNR order in my medical record or plan of care, even if we have both signed this form.

☐ No expiration date OR ☐ Expires on: _____

Patient Signature _____ Date Signed _____

FOR PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER TO COMPLETE:

By my signature I affirm that:

(i) After meeting with this patient and discussing this decision, I am satisfied that the patient understands the potential risks, burdens and benefits of refusing resuscitative interventions in light of the patient's medical condition; and (ii) I believe that the patient has made a voluntary informed decision about resuscitation and I agree to comply with that decision. I will tell any health care providers providing care under my authority to comply with this decision.

_____ _____

Signature and license level (MD, DO, PA or NP) Date Signed

_____ _____

Printed Name Telephone Number

THIS FORM IS ENDORSED BY MAINE EMERGENCY MEDICAL SERVICES



mainehealth.org