BCHIP
Bucks County Health Improvement Partnership
Improving Health ~ Enhancing Lives

Advance Healthcare Directive

For _____ Date of Birth _____

I,_____ , of _____ County, Pennsylvania, make this Advance Healthcare Directive of my own free will. I ask that my family, loved ones and caregivers honor my wishes which are intended to lessen any burden placed on them and minimize any feelings of guilt.

If I am permanently unconscious or have an end-stage medical condition where I am unable to express my wishes, I ask my agent, family, and care providers to honor my wishes as indicated below. *(initial one option)*

Initial: ____ I want life-sustaining medical care, and I wish to receive all medical and surgical treatment needed to keep me alive as long as possible, even if my doctor believes that it will only delay the time of my death or maintain me in a state of permanent unconsciousness.

OR ____ I do not want life-sustaining treatment and want to allow natural death to occur. I direct that I be given healthcare treatments (including medical and surgical treatments) to relieve pain and provide comfort. Treatments I would not want if I have reached this point include CPR (cardio-pulmonary resuscitation).

In case of Brain Damage or Disease

If I suffer from severe brain damage or disease with no realistic hope of significant recovery, then I want to be treated as though I have an end stage medical condition or am permanently unconscious. *(Initial one option)*

Initial: ____ I agree

OR ____ I do not agree

Organ Donation

Initial: ____ I consent to donate any organs or tissue if I am a candidate.

OR ____ I do not consent to donate any organs or tissues.

Based on My Reflections and Conversations

The following statements express my views on quality of life, comfort care and other instructions I want my agent to know about my wishes.

Quality of Life

If I ever lose my ability to communicate my wishes, my healthcare agent shall make decisions consistent with my stated desires and values and is subject to any special instructions or limitations that I may list here. I want my healthcare agent to make decisions that, in his or her best judgment, would best achieve the acceptable quality of life I have outlined below.

To me an acceptable quality of life is when I can: *(See Guidelines to help your reflection)*

Comfort Care

The following are important to me for comfort and peace of mind:

Other Instructions

Other Instructions I want my healthcare agent to follow based on my moral, religious, or ethical considerations:

My Healthcare Agent

Initial: ____ I do want to name a healthcare agent.

OR ____ I do not want to appoint a healthcare agent at this time and direct my healthcare providers to follow my instructions for my acceptable quality of life.

If I am no longer able to make my own healthcare decisions, the person I choose as my healthcare agent is:

Name of agent: _____ Relationship: _____

If my agent is unable to serve for any reason, then my choice for healthcare agent is:

First alternate agent: _____ Relationship: _____

If my alternate agent is unable to serve for any reason, then my choice for healthcare agent is:

Second alternate agent: _____ Relationship: _____

For current contact information, see attached page.

Healthcare Agent's Powers

I want my healthcare agent to be able to do the following:

1. To authorize, withhold, or withdraw medical care and surgical procedures.
2. To authorize, withhold, or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries, or veins.
3. To authorize my admission to or discharge from a medical, nursing, residential, or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.
4. To hire and fire medical, social service, and other support personnel responsible for my care.
5. To take any legal action necessary to do what I have directed.
6. To request that a physician responsible for my care issue a Do Not Resuscitate (DNR) or Allow Natural Death (AND) order, including an out-of-hospital DNR or AND order, and sign any required documents and consents.

HIPAA Authorization

I authorize all healthcare providers and insurers to disclose to my healthcare agent (personal representative), upon my healthcare agent's request, any information, including medical records, regarding my physical or mental health which may be private and protected by law. *(Initial one option)*

Initial: ____ I agree

OR ____ I do not agree

Making This Document Official

Having carefully read this document, I have signed it on this _____ day of _____, 20___, revoking all previous healthcare directives, healthcare powers of attorney, living wills, and medical healthcare treatment instructions.

_____
Signature (Principal)

_____ _____
Witness Address

_____ _____
Witness Address

Current Healthcare Agent Contact Information

Supplement to Advance Healthcare Directive

Current as of: _____, 20_____

Healthcare agent appointed in my Advance Directive:

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

First alternative Healthcare agent appointed in my Advance Directive:

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

Second alternative Healthcare agent appointed in my Advance Directive:

Name: _____ Relationship: _____

Address: _____

Phone: _____ Email: _____

Recommended distribution of copies of your Advance Healthcare Directive:

- □ ***Your agent(s), family members and loved ones***
- □ ***Your primary care physician (and specialist if appropriate)***
- □ ***Your hospital of choice***
- □ ***Others who should know your choices, such as, your pastor or attorney***
- □ ***Fill in the wallet card and keep it next to your insurance cards***
- □ ***Carry Advance Healthcare Directive with you when you travel***
- □ ***Consider putting copy in glove compartment in car and/or posting on refrigerator***

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Advance Directive Client Distribution Request Form

I request that Bucks County Health Improvement Partnership (BCHIP) copy and send my Advance Directive (which describes my healthcare wishes and names my healthcare agent) to the below listed individuals and institutions.

Client Name-Print: _____

Client Name-Signature: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Primary Care Physician:

Name: _____

Address: _____

Phone: _____ Fax: _____

Office documentation - Mailed/Given at appointment: _____

Preferred Hospital (more than one can be listed):

Name: _____

Name: _____

Name: _____

Office documentation - Processed: _____

Physician Specialist (if more than one - use reverse side): **[ ] More on reverse/attached**

Name: _____

Address: _____

Phone: _____ Fax: _____

Office documentation - Processed: _____

Administrative notes: _____ **[ ] Originals given at appointment**

[ ] In addition to my original document being returned to me, I request _____ of copies

[ ] I would like a PDF copy emailed to me

[ ] I request my document be sent to my healthcare agents by: [ ] Mail [ ] PDF by their email [ ] N/A