DESIGNATION OF HEALTH CARE SURROGATE

I, (NAME) _____, want to choose how I will be treated by my health care team.

INSTRUCTIONS FOR MY HEALTH CARE SURROGATE:

If I am unable to express my wishes or make my medical decisions, my health care surrogate (HCS) will:

- Talk to my health care team and have access to my medical information
- Authorize my treatment or have treatment stopped based on my choices and values
- Authorize transportation to another facility if needed
- Make decisions about organ/tissue donation based on my choices
- Apply for public benefits, such as Medicare/Medicaid, on my behalf
- Ensure my comfort and management of my pain
- Involve palliative care as a way to ensure my comfort
- Honor my written or oral wishes for end-of-life as designated in my living will

My health care surrogate's authority only begins when my doctor decides that I am unable to make my own health care decisions, UNLESS I initial either or both of the following boxes:

_____ My health care surrogate can receive my health information immediately.

_____ My health care surrogate can make health care decisions immediately.

If I am able to make decisions and disagree with any choices made by my health care surrogate, MY choices will be honored.

I designate as my health care surrogate:

Name Relationship Phone

Address

If my health care surrogate is not willing, able or reasonably available to perform his or her duties, I designate as my alternate health care surrogate:

Name Relationship Phone

Address

Other instructions/Optional information (such as quality of life, cultural, spiritual, religious or personal beliefs): _____

LIVING WILL

I understand that this living will becomes effective only when I am no longer able to express my wishes or I am not able to make my health care decisions AND when two physicians have determined that I have one of the following:

- A terminal or end-stage condition, and there is little or no chance of recovery
- A condition of permanent and irreversible unconsciousness, such as coma or vegetative state
- An irreversible and severe mental or physical illness that prevents me from expressing my wishes with others, recognizing my family and friends, or caring for myself in any way

_____ **Initial here if you choose not to complete the Living Will portion of this form at this time.**

My specific choices if, I have one of the above conditions	*(Please circle the option you prefer)*	
Cardiopulmonary resuscitation (CPR) if my heart or breathing stops	**YES, I want**	**NO, I do not want**
A breathing machine if I am unable to breathe on my own	**YES, I want**	**NO, I do not want**
Nutrition and fluids through tubes in my veins, nose or stomach	**YES, I want**	**NO, I do not want**
Kidney dialysis, a pacemaker or defibrillator, or other such machines	**YES, I want**	**NO, I do not want**
Surgery or admission to a hospital Intensive Care Unit	**YES, I want**	**NO, I do not want**
Medications that can prolong my dying, such as antibiotics	**YES, I want**	**NO, I do not want**

Indicate additional choices by placing your initials by the statements below.

_____I want my health care surrogate/proxy and my healthcare providers to ensure my comfort and management of my pain. I understand that the use of pain medications may cause side effects, such as drowsiness or confusion.

_____I want palliative care provided to ensure my comfort.
(Palliative care provides relief from the symptoms, pain and stresses of any serious illness. Palliative care can be provided along with curative treatment.)

_____To ensure my comfort, I want hospice involved in my care at the earliest opportunity.
(Hospice care focuses on comfort and quality of life rather than a cure.)

Make It Legal: *(Your health care surrogate(s) cannot serve as a witness to this document. At least one witness must be someone other than your spouse or a blood relative.)*

I fully understand the meaning of this form; I am emotionally and mentally competent to make decisions listed in this form and have given these decisions careful thought.

Your signature Print name Date Time

First Witness:

Signature Print Name

Address

Date/Time

Second Witness:

Signature Print Name

Address

Date/Time

PATIENT