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 communicate 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: _____

Address: _____

Phone: _____

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:

Alternate surrogate:

Name: _____

Address: _____

Phone: _____

(signatures on next page)

Other instructions: _____

_____

LIVING WILL

I understand that this living will becomes effective only when I am no longer able to communicate 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 communicating 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 CHECK MARK YOUR CHOICE	
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** ☐
Palliative care provided to relieve pain, symptoms and stresses	**Yes, I Want** ☐	**No, I Do Not Want** ☐
Hospice involved in my care at the earliest opportunity	**Yes, I Want** ☐	**No, I Do Not Want** ☐

Optional Information (such as quality of life, cultural, spiritual, religious or personal beliefs):

_____

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

WITNESSED BY:

First witness signature Print name Date

First witness address City State Zip

Second witness signature Print name Date

Second witness address City State Zip