

ADVANCE DIRECTIVE FOR HEALTH CARE* (Tennessee) * This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Part 1 Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____
Address: _____
Mobile Phone: _____ Alternate phone: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____
Address: _____
Mobile Phone: _____ Alternate phone: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. I do not give such permission (this form applies only when I no longer have capacity).

Part 2 Indicate Your Wishes for Quality of Life: By marking “yes” below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking “no” below, I have indicated conditions I would **not** be willing to live with (that to me would create an **unacceptable** quality of life).

<input type="checkbox"/> <input type="checkbox"/> Yes No	Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
<input type="checkbox"/> <input type="checkbox"/> Yes No	Permanent Confusion: I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
<input type="checkbox"/> <input type="checkbox"/> Yes No	Dependent in all Activities of Daily Living: I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
<input type="checkbox"/> <input type="checkbox"/> Yes No	End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked “no” above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking “yes” below, I have indicated treatment I want. **By marking “no” below, I have indicated treatment I do not want.**

<input type="checkbox"/> <input type="checkbox"/> Yes No	CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
<input type="checkbox"/> <input type="checkbox"/> Yes No	Life Support / Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
<input type="checkbox"/> <input type="checkbox"/> Yes No	Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
<input type="checkbox"/> <input type="checkbox"/> Yes No	Tube feeding/IV fluids: Use of tubes to deliver food and water to a patient’s stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Part 3 Other instructions, such as hospice care, burial arrangements, etc.:

(Attach additional pages if necessary)

Part 4 Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

_____ Any Organ/Tissue

_____ My Entire Body

_____ Only the following Organs/Tissues:

_____ No Organ or Tissue Donation

Part 5 SIGNATURE

Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: _____

Date: _____

Printed Name: _____

Block A:

Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

Signature of witness number 2

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

Signature of Notary Public

My Commission Expires: _____

WHAT TO DO WITH THIS ADVANCE DIRECTIVE: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; (4) provide a copy to the person(s) you named as your health care agent.

Warning to person executing this document

This is an important legal document. Before executing this document you should know these important facts: This document gives the person you designate as your agent (your attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document. Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped or withheld if you object at the time. This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose or treat a physical or mental condition. This power is subject to any limitations that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent: (1) authorizes anything that is illegal; or (2) acts contrary to your desires as stated in this document. You have the right to revoke the authority of your agent by notifying your agent or your treating physician, hospital or other health care provider orally or in writing of the revocation. Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document. Unless you otherwise specify in this document, this document gives your agent the power after you die to: (1) authorize an autopsy; (2) donate your body or parts thereof for transplant or therapeutic or educational or scientific purposes; and (3) direct the disposition of your remains. **If there is anything in this document that you do not understand, you should ask an attorney to explain it to you.**