APPOINTMENT of HEALTHCARE SURROGATE and LIVING WILL

I, _____, want to choose how I will be treated by my healthcare
PRINT NAME
providers. If I am unable to communicate or make my healthcare decisions because of illness or injury, I want my healthcare providers, **healthcare surrogate** (**HCS**) and loved ones to follow this living will.

In the event that I am unable to communicate or make my medical decisions, my HCS may:

- Talk to my healthcare providers and have access to my medical information
- Authorize my treatment or have it withdrawn based on my choices
- Authorize transportation to another facility
- Make decisions regarding organ/tissue donation based on my choices
- Apply for public benefits, such as Medicare/Medicaid, on my behalf

PART 1: CHOOSE A HEALTHCARE SURROGATE (HCS)

In the event that I am unable or unwilling to communicate or I am incapable of making my decisions about receiving, withholding or withdrawing medical procedures or other treatments, I designate my healthcare surrogate (HCS) to make choices for me according to his/her understanding of my choices and values.

My Appointed HCS

Name:_____

Address:_____

Phone:_____ Alternate phone:_____

Email:_____

Alternate HCS (If my appointed HCS is unwilling, unable, or not reasonably available)

Name:_____

Address:_____

Phone:_____ Alternate phone:_____

Email:_____

HEALTHCARE SURROGATE AUTHORITY (HCS)

My HCS's authority becomes effective when my healthcare provider determines that I am unable to make my own healthcare decisions, unless I initial either or both of the following statements.

If I initial here _____ my HCS's authority to receive my health information takes effect immediately. (upon signing this document)

If I initial here _____ my HCS's authority to make healthcare decisions for me takes effect immediately. (upon signing this document)

While I am able to make my own decisions, my choices will determine the kind of medical treatment I will receive. My healthcare providers will clearly communicate with me about my treatment and any changes even if I allow my HCS to make decisions immediately.

PART 2: INDICATE YOUR MEDICAL CHOICES

I understand that this living will only becomes effective when I am:

1. No longer able to communicate or when I am not capable of making my healthcare decisions known **AND**
2. 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 a coma or vegetative state
   - ⇒ An irreversible and severe mental or physical illness, such as end-stage dementia, that prevents me from communicating with others, recognizing my loved ones or caring for myself in any way

If I develop one of these conditions, I want my healthcare providers and my HCS to follow the choices I have made in this living will.

My specific choices if I have one of the above conditions	**Circle Your Choice**	
Cardio-pulmonary resuscitation (CPR) if my heart and breathing stops	Yes I Want	No I Do Not Want
A breathing machine (ventilator) 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 a 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

Place your initials by the statements below that are important to you.

_____ I want my HCS and my healthcare providers to ensure my comfort and the 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.)

PART 3: INDICATE GOALS OF CARE

This page is optional, but highly recommended.

Suppose there is a time when you are too sick or hurt to communicate. Your healthcare providers believe there is little chance you will recover the ability to know who you are or who you are with. What would be most important to you in this situation? (level of care, location of care, description of a good quality of life) _____

What cultural, spiritual, religious or personal beliefs do you have that you want your healthcare providers to know about? (customs, practices, meals, services, music)

Please contact my religious/spiritual advisor to support me.

Name:_____

Contact information:_____

I want my HCS, loved ones, and healthcare providers to know these things about me. What fears, worries or concerns do you have about serious illness or injury?_____

PART 4: MAKE IT LEGAL

I fully understand the meaning of this Appointment of Healthcare Surrogate and Living Will. I am emotionally and mentally capable of signing this document. This document reflects my personal choices regarding medical care.

_____ _____ _____

Signature Printed name Date

Witness 1: _____ _____

Print name Signature

Address: _____

Witness 2: _____ _____

Print name Signature

Address: _____

**** Your healthcare surrogate(s) cannot serve as a witness to this living will.***
At least one witness must be someone other than your spouse or a blood relative.

Next Steps

- ☐ Discuss your living will with your healthcare provider(s).
- ☐ Communicate your choices to your HCS and alternate surrogate.
- ☐ Once your living will has been signed and witnessed, give copies to: your doctor(s), your HCS and alternate surrogate and your loved ones.
- ☐ Keep your original copy where it can be easily found.
- ☐ Review your living will on a regular basis. A living will can be changed at any time.

Copies of this document have been given to:_____

_____

*The state of Florida does **NOT** require notarization of living wills, however some states do. Please check your state's requirements. This space is being provided for those individuals who need notarization.*

Signature: _____County of: _____

The foregoing instrument was acknowledged before me on _____ (date).

By: _____Signature of Notary: _____

Seal of Notary:

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