Alabama Advance Directive

Explanation and Instructions – Abbreviated

* Please read the entire information booklet about the Alabama Advance Directive before you complete the advance directive form.

1. While Alabama law provides for its citizens to have advance directives, there is no requirement in the law that anyone must have one. Citizens may develop their own advance directives by signing a form which contains all the necessary elements the law specifies such as that found elsewhere on this website. A citizen may wish to have his own attorney or an elder law attorney prepare his advance directive. Forms for advance directives are generally available at hospitals, hospices, home health agencies and nursing homes across the nation. Each state has its own laws governing end of life issues including advance directives, and it is best to do an advance directive for the state in which you live. In Alabama, one must be at least 19 years of age to complete an advance directive and must be able to think clearly and make decisions.
2. If one decides to develop an advance directive, he/she will have more say over how much treatment he gets should he/she ever be unable to communicate his wishes due to a terminal illness or a permanent unconscious state.
3. The main purpose of an advance directive is to prompt people to analyze, discuss with their families, and decide what they do and do not want regarding end-of-life medical care should they ever be unable to communicate due to a terminal illness or permanent unconscious state. When the person decides what he/she does or does not want in the way of end-of-life medical care, he/she needs to communicate those wishes to the family, doctor, minister, priest, rabbi, attorney and any significant others. Each should be given a copy of the advance directive. The original document needs to be kept in an accessible, safe place in the home – NOT in a safe deposit box.
4. Instructions contained in a completed advance directive only go into effect when:
    a. The person's doctor has a copy of it,
    b. The person's doctor has concluded that he/she is no longer able to make his/her own health care decisions and
    c. The person's doctor and another doctor have determined that he/she is in a terminal condition or a permanent unconscious state.
5. If a person signs an advance directive and later changes his/her mind, he/she can tear up the original document, complete a new one and distribute copies. The original should remain in an accessible, safe place in the home.
6. If a person needs help understanding the kinds of medical decisions he/she is able to make in the advance directive, he/she needs to discuss them with his/her doctor.
7. In the advance directive form on this website, there is a section where one is asked whether or not he/she wants to name a health care proxy (someone who will make medical care decisions for a person when he is no longer able to do so). If a health care proxy is named, that person needs to be one that is totally trustworthy. If a health care proxy is named, the person needs to be willing to serve and must sign the document to indicate his willingness. More than one proxy can be listed, but the first listed will be the primary proxy. All health care proxies must sign the document.
8. After completing the advance directive, the person must sign and date the form in the presence of two witnesses who are not related to the person by blood, marriage or adoption; who do not stand to gain financially by the person's death and who are not responsible for the person's medical care. The witnesses must sign the document, give their addresses and date their signatures. If a notary public is the witness, his is the only witness signature needed.

For help or further information, contact the Alabama Commission on Aging at (800) 243-5463 and/or Choice in Dying at (800) 989-9455.

This form may be used in the State of Alabama to make your wishes known about what medical treatment or other care you **would** or **would not** want if you become too sick to speak for yourself. You are not required to have an advance directive. If you do have an advance directive, be sure that your doctor, family, and friends know you have one and know where it is located.

Section 1. Living Will

I, _____, being of sound mind and at least 19 years old, would like to make the following wishes known. I direct that my family, my doctors and health care workers, and all others follow the directions I am writing down. I know that at any time I can change my mind about these directions by tearing up this form and writing a new one. I can also do away with these directions by tearing them up and by telling someone at least 19 years of age of my wishes and asking him or her to write them down.

If I become terminally ill or injured:

Terminally ill or *injured* is when my doctor and another doctor decide that I have a condition that cannot be cured and that I will likely die in the near future from this condition.

Life sustaining treatment – Life sustaining treatment includes drugs, machines, or medical procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your initials by either "yes" or "no":

I want to have life sustaining treatment if I am terminally ill or injured. ____ Yes ____ No

Artificially provided food and hydration (food and water through a tube or an IV) – I understand that if I am terminally ill or injured I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initials by either "yes" or "no":

I want to have food and water provided through a tube or an IV if I am terminally ill or injured.
____ Yes ____ No

If I become permanently unconscious:

Permanent unconsciousness is when my doctor and another doctor agree that within a reasonable degree of medical certainty I can no longer think, feel anything, knowingly move, or be aware of being alive. They believe this condition will last indefinitely without hope for improvement and have watched me long enough to make that decision. I understand that at least one of these doctors must be qualified to make such a diagnosis.

Life-sustaining treatment – Life-sustaining treatment includes drugs, machines, or other procedures that would keep me alive but would not cure me. I know that even if I choose not to have life sustaining treatment, I will still get medicines and treatments that ease my pain and keep me comfortable.

Place your initials by either "yes" or "no":

I want to have life-sustaining treatment if I am permanently unconscious. ____ Yes ____ No

Artificially provided food and hydration (food and water through a tube or an IV) – I understand that if I become permanently unconscious, I may need to be given food and water through a tube or an IV to keep me alive if I can no longer chew or swallow on my own or with someone helping me.

Place your initials by either "yes" or "no":

I want to have food and water provided through a tube or an IV if I am permanently unconscious. ____ Yes ____ No

Other directions: Please list any other things you want **done** or **not done**.

In addition to the directions I have listed on this form, I also want the following:

_____

_____

_____

_____

If you do not have other directions, place your initials here:

____ No, I do not have any other directions.

Section 2. If I need someone to speak for me

This form can be used in the State of Alabama to name a person you would like to make medical or other decisions for you if you become to sick to speak for yourself. This person is called a health care proxy. You do not have to name a health care proxy. The directions in this form will be followed even if you do not name a health care proxy.

Place your initials by only one answer:

____ I **do not** want to name a health care proxy *(if you check this answer, go to Section 3).*

____ I **do** want the person listed below to be my health care proxy. I have talked with this person about my wishes.

First choice for proxy: _____ Relationship to me: _____

Address: _____ City: _____ State: ___ Zip: _____

Day-time phone: _____ Evening phone: _____

If this person is not able, not willing or not available to be my health care proxy, this is my next choice:

Second choice for proxy: _____ Relationship to me: _____

Address: _____ City: _____ State: ___ Zip: _____

Day-time phone: _____ Evening phone: _____

Instructions for proxy:

Place your initials by either "yes" or "no":

I want my health care proxy to make decisions about whether to give me food and water through a tube or an IV. ____ Yes ____ No

*Place your initials by **only one** of the following:*

____ I want my health care proxy to follow **only** the directions listed on this form.

____ I want my health care proxy to follow my directions as listed on this form **and** to make any decisions about things I have not covered in the form.

____ I want my health care proxy to make the final decision, even though it could mean doing something different from what I have listed on this form.

Section 3. The things listed on this form are what I want

I understand the following:

- If my doctor or hospital does not want to follow the directions I have listed, they must see that I get to a doctor or hospital who will follow my directions.
- If I am pregnant, or if I become pregnant, the choices I have made on this form will not be followed until after the birth of the baby.
- If the time comes for me to stop receiving life-sustaining treatment or food and water through a tube or an IV, I direct that my doctor talk about the good and bad points of doing this, along with my wishes, with my health care proxy, if I have one, and with the following people:

  _____ _____

  _____ _____

Section 4. My signature

Your name: _____ Birth date (month, day, year): _____

Your signature: _____ Date signed: _____

Section 5. Witnesses (two signatures needed)

I am witnessing this form because I believe this person to be of sound mind. I did not sign the person's signature, and I am not the health care proxy. I am not related to the person by blood, adoption, or marriage and not entitled to any part of his or her estate. I am at least 19 years of age and am not directly responsible for paying for his or her medical care.

Name of first witness: _____

Signature: _____ Date: _____

Name of second witness: _____

Signature: _____ Date: _____

Section 6. Signature of Proxy

I, _____, am willing to serve as the health care proxy.

Signature: _____ Date: _____

Signature of second choice for proxy:

I, _____, am willing to serve as the health care proxy if the first choice cannot serve.

Signature: _____ Date: _____