MEDICAL RECORD NUMBER:

NAME:

BIRTH DATE:

DELIVERY NETWORK:

CMG COMMUNITY MEDICAL GROUP

Yale NewHaven Health Northeast Medical Group

Yale Medicine

Appointment of Health Care Representative/Agent

I _____ understand that, as a competent adult, I have the right to make decisions about my health care. However, there may come a time when I am unable to make my own health care decisions due to illness or incapacity. In these circumstances, those caring for me will need direction from someone who knows my values and health care wishes. By signing this appointment of health care representative/agent, I give the person named below legal authority to make health care decisions on my behalf in such case or at such time.

I appoint – Name _____

Address _____

Phone number _____

Cell phone number _____

to be my health care representative/agent. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment, **my health care representative/agent is authorized to (1) accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, (2) make the decision to provide, withhold or withdraw life support systems and (3) to receive any health care information about me that might be necessary to make these decisions, including information related to my mental health or HIV status.**

I direct my health care representative/agent to make decisions on my behalf in accordance with my wishes as stated in my living will, or as otherwise known to my health care representative/agent. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative/agent may make a decision in my best interests, based upon what is known of my wishes.

If this person is unwilling or unable to serve as my health care representative/agent, I appoint:

Name _____

Address _____

Phone number _____

Cell phone number _____

to be my alternative health care representative/agent.

This request is made, after careful reflection, while I am of sound mind and will remain in effect unless and until it is revoked in accordance with state law.

Date | Patient's Printed Name | Patient's Signature

WITNESSES' STATEMENTS

This document was signed in our presence by _____ the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

First Witness

Date _____ Witness Printed Name _____ Witness Signature _____

Address _____ City _____ State _____ Zip Code _____

Second Witness

Date _____ Witness Printed Name _____ Witness Signature _____

Address _____ City _____ State _____ Zip Code _____

INSTRUCTIONS FOR SCANNING INTO EPIC

1. Scan into Media Manager
2. For document type, select "Healthcare Representative/POA"

MEDICAL RECORD NUMBER:

NAME

BIRTH DATE:

DELIVERY NETWORK:

CMG COMMUNITY MEDICAL GROUP

Yale NewHaven Health Northeast Medical Group

Yale Medicine

Treatment Preferences and Living Will

I am providing the information below to help my physicians and care team understand my care choices, particularly to help them understand my wishes relating to end-of-life care.

☐ I already have a Living will or Advance Directive that I wish to be read in conjunction with this document.

☐ I do not already have a Living Will or other Advance Directive, and would like Part 2 of this document to serve as my Living Will, and be read in conjunction with this document.

****

Part 1. Information About My Treatment Preferences

If I am no longer able to make my own health decisions, the information I have provided below outlines my goals and preferences for care at the end of life.

Future health situations:

- When you think about your health and health situations you may experience in the future, how do you feel?
  - ☐ Life is always worth living no matter what type of serious illness, disability, or pain I may be experiencing.
  - ☐ There may be some health situations that would make my life not worth living.
- How do you balance quality of life with medical care? If you had serious illness, what would be important to you?
  - ☐ I want medical treatments to try to live as long as possible. I would not want to stop treatment even if I were in pain, could not feed or care for myself, or needed machines to live.
  - ☐ I want to try treatments for a period of time, but I don't want to suffer. If after a period of time the treatments do not help or I am suffering, I want to stop.
  - ☐ I want to focus on my quality of life and being comfortable, even if it means having a shorter life.

In the event of serious illness:

- If I am terminally ill or so ill that I am unlikely to get better
  - ☐ I would not want to receive treatment to try to keep me alive
  - ☐ I would want to receive treatment to try to keep me alive
- If my doctors decide that I am likely to die within a short period of time, and life support treatment would only delay the moment of my death:
  - ☐ I would not want to receive treatment to try to keep me alive
  - ☐ I would want to receive treatment to try to keep me alive
- If my doctors decide that I am in a coma from which I am not expected to wake up or recover, and life support treatment will only delay the moment of my death:
  - ☐ I would not want to receive treatment to try to keep me alive
  - ☐ I would want to receive treatment to try to keep me alive
- If my doctors decide that I have permanent and severe brain damage, and I am not expected to get better, and life support treatment would only delay the moment of my death:
  - ☐ I would not want to receive treatment to try to keep me alive
  - ☐ I would want to receive treatment to try to keep me alive

Part 2. Living Will

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a statement of my wishes.

As the author of this document, I request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, that the treatment options outlined below be followed. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

Treatment Options at the end of life

If I have a terminal illness and am close to death or am unconscious and not likely to wake up, I want the following care:

- If my heart stops:
  - ☐ I would want cardio pulmonary resuscitation done to try to restart my heart
  - ☐ I would not want cardio pulmonary resuscitation done to try to restart my heart; if I have an implanted automatic defibrillator in place, I want to have the defibrillator turned off.

- If I'm unable to breathe on my own:
  - ☐ I would want a breathing machine
  - ☐ I would not want a breathing machine for any length of time

- If I am terminally ill or so ill that I am unlikely to get better, and I am unable to swallow enough food and water to stay alive:
  - ☐ I would want a feeding tube
  - ☐ I would not want a feeding tube

****

This request is made, after careful reflection, while I am of sound mind.

Patient's Printed Name	Patient's Signature	Date

****

Part 3 – Witnesses' Statements

WITNESSES' STATEMENTS

This document was signed in our presence by the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

First Witness

Witness Printed Name	Witness Signature	Date

Address	City	State	Zip Code

Second Witness

Witness Printed Name	Witness Signature	Date

Address	City	State	Zip Code

(Note – this form requires two witnesses, but does not require a notary, to be valid)

INSTRUCTIONS FOR SCANNING INTO EPIC

1. Scan into Media Manager
2. For document type, select "Living Will"
   Made Fillable by eForms