



Maine Health Care Advance Directives

My Name (please print) _____

My Address _____

My Birthplace _____

I have given copies of this form to: _____



About Your Health Care Advance Directive

A Description of Maine Law on Health Care Advance Directives

Choosing your care.

When you need medical care, you have the right to make choices about that care. But there may come a time when you are so sick that you cannot make your choices known. You can stay in charge by putting your choices in writing ahead of this time. This is called giving *advance directives*.

What is an advance directive?

Under Maine law, any spoken or written decision or instruction about the health care you want in the future is called an advance directive. You can tell your doctor or family what you want. But it is best to write it down.

Advance directives also are sometimes called *living wills* and *durable health care powers of attorney*. If you have already signed one, be sure your doctor, your hospital and your family have a copy. If you have not signed a form, you may use the health care advance directive available for you in this clinical area. Simply ask your caregiver or care provider for a copy of this form.

Who can complete an advance directive?

Anyone living in Maine who is 18 years of age or older can complete an advance directive. If you are younger than 18, you may also be able to complete an advance directive under other certain, limited circumstances.

How does an advance directive help?

If you sign an advance directive, your family and your doctor will know who to talk to about your care or what kinds of treatment you want or do not want when you are too sick to decide. This could happen if you have a serious illness, are near the end of life, or are no longer aware. If doctors do not know your wishes, they will treat you until they can ask your family what you want. If your family does not know, you may get treatments you do not want or which you would stop if you had your way. In an emergency, you will receive care until the doctors can determine your condition and what your wishes are. If you do not have an advance directive, Maine law allows your doctors to ask your relatives – and perhaps others close to you – to make decisions about your care, as explained below.

What do I choose in an advance directive?

Most advance directive forms allow you to do five things:

1. Choose someone to make all your health care decisions beginning either right away or when you are too sick to decide. That person is called your *agent*. Your agent can be a family member or friend. If you choose an agent, two (2) witnesses must sign your advance directive.
2. Choose whether or not you want certain treatments when you are no longer aware, very ill, or may not live. For example, you can choose what you wish to have done or not done if you are dying, or if you are in a permanent coma. Your agent must follow any choices you make in an advance directive.
3. State a desire to donate your organs. (Your family will make the final decision, but this will tell them your wishes.)
4. Name your primary doctor.
5. State your wishes or name someone to decide funeral and burial matters.

What happens if my heart stops in the hospital or nursing home?

If your heart or breathing suddenly stopped in the hospital or nursing home, drugs, machines and other means will be used to try to restart them. This is called *cardiopulmonary resuscitation* or CPR. CPR is always done unless you direct your doctor and the health care team to do otherwise. If you do, your doctor will write an order called a “Do Not Resuscitate” order or DNR. If you have concerns about CPR, discuss them with your doctor while you are well.

What happens if my heart stops when I am at the hospital for an outpatient visit, getting blood work done or having an XRAY?

In an emergency, you will receive care until the doctors can determine your condition and what your wishes are. This may mean that you might receive CPR until you can be transferred to the Emergency Department and your Medical Record with your advance directive can be obtained. Once your wishes are known, they will be followed.

What if my heart stops at home?

If you are at home and your heart stops, ambulance crews may still give you CPR even if you have an advance directive. You should talk with your doctor if you do not want CPR at any time. If you and your doctor have both signed the orange form, then your decision not to have CPR should be followed. Show that form to those close to you and keep it where it will be easily seen. Your doctor will then give you a special bracelet or wallet card designed to alert the ambulance crews that you do not want CPR.

When does my advance directive go into effect?

You can fill out the form in either of two ways to decide when it goes into effect. You may want your advance directive to be used only when you are too sick to choose your care or tell others what care you want. If you fill out the form this way, your doctor will decide when the form goes into effect. Or, you may fill out the form so your agent can make those decisions right away, but you will still be told about them.

If I do not have an agent or an advance directive, who will decide my care when I am too sick to choose?

If you do not name an agent or do not have an advance directive, the doctor will ask your loved ones what treatment you would want, in this order: Your spouse (unless legally separated); someone with whom you share an emotional, physical and financial bond similar to a spouse; your adult children; your parents; your adult brothers and sisters; your adult grandchildren; your adult nieces and nephews; your adult aunts and uncles. If there are family members whom you do NOT want to make decisions for you, you need to put this in writing and give a copy of it to your doctor or hospital.

If the doctor cannot reach a family member, the doctor may ask another adult relative or good friend who knows your wishes or your life values.

What happens if I do not make an advance directive?

Your family can tell your doctor to continue to treat you. They can also tell your doctor to stop or not give treatment to keep you alive (life sustaining treatment) if you are dying or in a permanent coma. They may also make some other decisions for you if you are no longer aware and there is no guardian or advance directive, but no one may deny surgery or procedures to save your life if your doctor thinks they are necessary.

Does my doctor have to follow my choices?

Yes. If your doctor, hospital, or other place of health care has any special rules about health care decisions, or if they will not carry out your decisions, they must tell you. They must then arrange to move you to a doctor, hospital, or other place that WILL carry out your decisions.

What rights do I have as a patient?

When you need medical care, you have certain rights, including the right to refuse care. You have a right to know:

- What your medical problem is and what tests and treatments may be needed;
- What the doctor thinks can be done and what the usual risks may be;
- If there are other ways to care for you; and
- What may happen if you refuse care.

What else should I know?

Every hospital, nursing home and many other places that provide health care in Maine have these forms or can tell you how to get them. If you are hospitalized at Mercy Hospital, just ask your doctor or nurse. They can explain the forms, but they cannot give you legal advice. You can also call Mercy Hospital's Care Management Services office at (207) 879-3205 and request a copy of these forms.

No one can make you sign a form or stop you from signing it. You also have the right to change or cancel a form at any time. If you do so, just notify your physician of this change. It is always helpful to also forward any changes to the Health Information Services department of Mercy Hospital that will retain your current wishes in your medical record. An advance directive form does not allow anyone to violate laws regarding mercy killing and euthanasia.

If you have a complaint about how a hospital or other provider of health care handles your advance directive, you can contact:

Licensing Division
Maine Department of Human Services
11 State House Station
Augusta, Maine 04333-0011
(207) 287-9300

The advance health care directive form does not allow others to control your money or property. To appoint someone to control your money and property, you need a different form – a financial power of attorney – and you should discuss that with your lawyer.

Remember:

You can plan in advance for the time when you may not be able to state your health care choices. Talk with your doctor, family members, clergy and others about your wishes. Put your decisions in writing. This may save your family and others from having to make painful decisions later on.

You can use the form available for you at Mercy. The directions about how to fill it out are with the form. You can use a different form if you want. You do not need a lawyer, although you may want to speak with one. After you sign the form, put the original in a safe place and be sure to give copies to your family, your doctor, and your hospital. You will have earned their thanks and your own peace of mind.



144 State Street • Portland • ME 04101
207-879-3000
www.mercyhospital.org

Maine Health Care Advance Directive Form

You may use this form now to tell your physician and others what medical care you want to receive if you become too sick in the future to tell them what you want. **You may choose to fill out the whole form or any part of the form and then sign and date the form in Part 6.** These are the parts:

Part 1	Fill this out if you want to choose someone to make all your health care decisions for you, either right away or if you become too sick to tell others what you want. This person is called your agent.
Part 2	Fill this out if: (1) you did not name an agent in Part 1 and now want to choose whether you want certain treatments or , (2) you did name an agent in Part 1 and want to tell your agent your wishes about certain treatments, knowing that your agent must follow your directions.
Part 3	Fill this out if you want to give the name of your primary physician, physician assistant or nurse practitioner.
Part 4	Fill this out if you want to make decisions about donating your organs, body or tissues after your death.
Part 5	Fill this out if you want: (1) to choose someone to make all funeral and burial decisions after your death, or (2) to tell your family any wishes you have about funeral and burial decisions.
Part 6	You must sign and date your Advance Directive form on this page. Have two witnesses sign the form at the same time you sign it. Tell others about your decisions and give copies to your physician, other health care providers, family and hospital.
Part 7	If you do not wish to be revived by ambulance crews should your heart or breathing stop, then you and your physician (or nurse practitioner or physician assistant) need to sign this Do Not Resuscitate (DNR) form.

Note

You may change any part of this form except for Part 6 and Part 7. You may cross out any words, sentences, or paragraphs you do not want. You can also add your own words. If you make any changes to the form, it is best if you put your initials and the date next to each change so that everyone knows it was your decision to make the change. The form lets you choose different ways to handle your care by checking boxes or filling in blanks. You may initial each box and each blank you fill in to show that it was your decision to check the box or fill in the blank.

Before filling out this form, we suggest that you talk with your lawyer, family members, physicians, and others close to you about your wishes. If you make changes or complete a new form, be sure to let everyone know.

My Name *(please print)* _____

My Address _____

My Birth date _____

This is a list of all the people who have copies of my signed health care advance directive:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Part 1 – Power of Attorney for Health Care

Instructions:

This part lets you choose another person to make health care decisions for you, either right away or when you are too sick to choose your own care. The person you choose is called your agent. You may also name a second and third choice to be your agent, if your first choice is not willing, reasonably available or able to make decisions for you. If you choose an agent on this form, but do not fill out any other parts of the form, your agent will be able to:

- Make all health care decisions for you, including decisions regarding tests, surgery and medication;
- Decide whether or not to have food or fluids given to you through tubes or fed into your veins through an IV;
- Decide whether or not to use treatments or machines to keep you alive or to restart your heart or breathing;
- Choose who will give you health care and where you will get it, such as hospitals, nursing homes, assisted living settings, home health, or hospice care; and
- Make any health decision he or she believes would be consistent with your values or in your best interest, even if it is not listed in the form.

Who can be your agent:

You can name any adult you trust to be your agent, except your agent may not be the owner, operator or employee of a nursing home or residential long-term care facility where you are receiving care, unless that person is your relative.

How your agent must make decisions:

If your agent does not know what you want, the agent must make decisions consistent with your personal values, if known, or based on your best interests. In Part 2, you can decide what you want in advance. If you make choices in Part 2, your agent must make decisions based on those choices.

Who can see your health care information:

Once your agent has the right to make health care decisions for you, your agent can look at your medical records and consent to giving your medical information to others. The state and federal privacy laws let your agent see all of your health information so that he or she can make the right decision for you.

The first part of your advance directive begins on the next page.

YOUR ADVANCE DIRECTIVE BEGINS HERE

Choosing an agent: Fill in your name and the name of the person you choose to be your agent to make health care decisions for you here:

My name _____

My agent's name _____

Title or relationship to me _____

My agent's address _____

My agent's home phone (____) _____ My agent's work phone (____) _____

If the agent I have named above is not willing, reasonably available or able to make decisions for me, I choose the following person to be my agent:

Choice # 2 to be my agent

Name _____

Title or Relationship to me _____

Address _____

Home Phone (____) _____

Work Phone (____) _____

If the person I have named as Choice # 2 is not willing, reasonably available or able to make decisions for me, I choose the following person to be my agent:

Choice # 3 to be my agent

Name _____

Title or Relationship to me _____

Address _____

Home Phone (____) _____

Work Phone (____) _____

You may change your mind later about who you want to be your agent. If you want to stop the agent you have named from making decisions for you, you must tell your primary physician or fill in these blanks:

I do **not** want _____ to be my agent. _____

My signature

Date you filled out and signed this section _____

Any time you cancel, replace or change this form you should give copies of the changed or new form to everyone who has a copy of your original form.

Advance Directive For: _____

Your agent's power:

When your agent can start making decisions for you: (Check only one box: A or B)

A. My agent can make decisions only when my primary physician or a judge decides that I am too sick to make my own health care decisions.

OR

B. My agent can start making health care decisions for me right away, but this does not mean I have given up the right to make my own decisions if I am still able and willing to make my own decisions. When my agent makes a health care decision for me, I will be told, if possible, about that decision before it is carried out unless I say I do not want to know. If I disagree with that decision and am still able to decide, I can make a different decision. As long as I am able, I can end my agent's right to make decisions for me, change my agent or make my own decisions. If I want to end my agent's right to make decisions for me, I must tell my primary physician or put my decision in writing and sign it with the date of my signature.

Nominating a guardian:

A guardian is a person chosen by a court to make decisions about your personal care. These decisions can include not only health care, but other decisions such as where you will live and how your personal needs will be met. If you wish, you may ask that a court assign your agent as your guardian, if appointment of a guardian should become necessary. Check the box below to nominate your agent to be your guardian, if a judge needs to appoint a guardian for you.

I nominate my agent to be my guardian if a judge needs to appoint a guardian for me.

If you want to nominate someone other than your agent to be your guardian, you may fill in the section below.

If a judge needs to appoint a guardian for me, I nominate the person named below as my guardian:

Name _____ Title or Relationship to me _____

Address _____

Home Phone (____) _____ Work Phone (____) _____

Advance Directive For: _____

Part 2 – Special Instructions

Instructions if you did not name an agent in Part 1:

If you did not name an agent in Part 1, you should fill out this Part to state what you want for care if you become too sick to make your choices known.

OR

Instructions if you did name an agent in Part 1:

If you named an agent in Part 1, you do not have to fill out this part of the form. If you want your agent to make all of your health care decisions, DO NOT fill out this part of the form. Your agent will make decisions in your best interests, including decisions to refuse treatment. However, you may fill out this part if you want to give special directions to your agent about your wishes, such as when you are near death, in a permanent coma or no longer able to make your own decisions. You may also cross out or add words. It is best if you put your initials and date next to any changes you make so everyone knows the changes were your decision. If you complete this part, your physician and others will follow these instructions and your agent cannot make a different decision. You may also write your wishes on another piece of paper, sign it, date it, and keep it with this form.

Life-Sustaining Treatment Choices:

You may check one of the two boxes below to show your choice about getting treatments that would keep you alive:

<p><input type="checkbox"/> <u>Choice not to be kept alive</u></p> <p>I do not want treatment to keep me alive if my physician decides that either of the following is true;</p> <p>(i) I have an illness that will not get better, cannot be cured, and will result in my death quite soon (sometimes referred to as a terminal condition),</p> <p>OR</p> <p>(ii) I am no longer aware (unconscious) and it is very likely that I will never be conscious again (sometimes referred to as a persistent vegetative state).</p>	<p><input type="checkbox"/> <u>Choice to be kept alive</u></p> <p>I want to be kept alive as long as possible within the limits of generally accepted health care standards, even if my condition is terminal or I am in a persistent vegetative state.</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Advance Directive For: _____

Life-Sustaining Treatment Choices:

You may also check one of the two boxes below to show your choice about treatment that would keep you alive if, in the future, you have late stage Alzheimer's disease or other severe dementia. These choices will not limit the authority under state law for your agent, surrogate, guardian or physician to make treatment choices if you are unable to make your own decisions and are **not** in late stage Alzheimer's disease or other severe dementia.

<p><input type="checkbox"/> <u>Choice not to be kept alive</u></p> <p>If my physician and a second physician decide that I am in the late stage of Alzheimer's disease* or other severe dementia, I do not want treatment to keep me alive.</p>	<p><input type="checkbox"/> <u>Choice to be kept alive</u></p> <p>I want treatment to keep me alive as long as possible within the limits of generally accepted health care standards, even if my physician and a second physician decide that I am in the late stage of Alzheimer's disease or other severe dementia.</p>
-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

* Only a physician can determine that someone is in the late stage of Alzheimer's disease. People in the late stages of Alzheimer's disease generally have a number of the following characteristics: loss of the ability to respond to their environment; loss of the ability to speak; loss of the ability to control movement; loss of the capacity for recognizable speech, although words or phrases may occasionally be uttered; needing help with eating and toileting; general incontinence of urine; loss of the ability to walk without assistance, then the ability to sit without support, then the ability to smile, and the ability to hold their head up; reflexes become abnormal; muscles grow rigid; and swallowing is impaired.

Tube Feeding: You may check one of the two boxes below to show your choice about tube feeding or having water and nutrition fed into your body through an IV or tube (artificial nutrition and hydration):

<p><input type="checkbox"/> Artificial nutrition and hydration should not be given, or should be stopped, based on the other life-sustaining treatment choices I made about keeping me alive on Pages 6 and 7.</p>	<p><input type="checkbox"/> Artificial nutrition and hydration should be given regardless of my condition.</p>
--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	----------------------------------------------------------------------------------------------------------------

Advance Directive For: _____

Part 3 — Primary Physician

This section is optional. Fill out this part only if you wish to name your primary physician today.

Name of my primary physician: _____

Address: _____ Phone: _____

I want any agent I named in Part 1 to talk with this physician about my health care. If the physician I have named above is not willing, reasonably available or able to carry out my wishes, I want the agent I named in Part 1 to talk with the physician listed below:

Name of physician: _____

Address: _____ Phone: _____

If you want your agent or those making decisions for you to speak with a nurse practitioner or physician assistant before making a decision, you may complete the following section:

Name of nurse practitioner or physician assistant: _____

Address: _____ Phone: _____

Advance Directive For: _____

Part 4 – Donation of Body, Organs or Tissues at Death

This section is optional. Fill out this part only if you want to give directions about donating your body, organs or tissues after your death.

I do **NOT** wish to donate any organs, tissues or parts.

I have checked below my choices about donating my body, organs or tissues after death. I have spoken with my family so that they will not object to my wishes after I die.

I give my body. **OR**

I give any needed organs, tissues or parts. **OR**

I give only the following organs, tissues, or parts:

My gift is for the following purposes (you may check any number of boxes):

My gift is for transplant or therapy for another person, to be chosen based on generally accepted health care standards.

My gift is for research and education. My preference, if any, is to give my body, organs, or tissues to the following hospital, medical school, or physician:

Name _____

Address _____

I understand that I may need to contact the hospital, medical school, or physician before I die in order for them to accept my body, organs or tissues after my death.

Advance Directive For: _____

Part 5 – Instructions About Funeral and Burial Arrangements

This section is optional. Fill out this part only if you wish to give special instructions about your funeral or burial arrangements here.

I hope that my family will follow my wishes after I die as noted below.

I choose _____ to have custody and control of my body after my death with the right to decide everything about my funeral and burial.

OR

I want my family to know these are my wishes about: burial, cremation, funeral, or memorial service.
(Fill in)

If you plan to die at home, talk with your physician and funeral director about your plans. When you die, your family or agent should call your physician and the funeral home you have chosen. The funeral home staff will pick up your body from your home.

Advance Directive For: _____

Part 6—Signing the Form

If you have filled out any part of this form, you must sign and date the form on this page. You must also have two other adults sign as witnesses at the same time you sign the form. Your agent cannot sign as a witness. You do not need to have a Notary Public sign your Advance Directive form to make it legal in Maine. However, if you travel or live part of the year out-of-state, it would be wise to have it signed by a Notary. Some states require this. You can find this service under Notary Public in the phone book. Most banks also have Notaries Public and will usually notarize papers for bank customers when asked. The Notary Acknowledgment may be done at any time after you sign this form.

Sign and date the form here:

Sign your name: _____ Your Address: _____
Print your name: _____
Date: _____

First witness:

Signature: _____ Address: _____
Print your name: _____
Date: _____

Second witness:

Signature: _____ Address: _____
Print your name: _____
Date: _____

Notary Acknowledgment.

Then personally appeared the above named _____, known to me or who presented satisfactory evidence of his/her identity, and acknowledged this Advance Directive as his/her free act and deed before me.

Notary signature: _____ Date: _____

Printed name: _____ Notary Public State of: _____ Commission Exp.: _____

Make sure to tell people. Tell your family members, physicians and others close to you what you have decided. You should talk to the agent(s) you have chosen to make sure that they understand your wishes and are willing to carry them out. Give a copy of this form to your physician, to any place where you get health care, and to any agent(s) you have chosen in Part 1. Please be sure to list the people who have copies of this form on the front page.

Canceling or changing the form.

Part 1: You may end your agent's right to make decisions while you are still able to make those decisions by telling your primary physician or putting your decision in writing and attaching it to this form. If you want to name a new agent, you must put that instruction in writing and sign it in front of two witnesses who must also sign their names.

Parts 2-7: You may cancel any other part of this form, or change your instructions in the other parts of this form while you are still able to make those decisions. It is best to do so by (1) writing on this form, (2) writing on another piece of paper and attaching it to this form, or (3) completing a new form. Any of those written changes should be signed and dated by you.

Part 7—Instructions to Emergency Medical Services (ambulance crews) about what to do if your heart or breathing stops.

This section is optional. If you do not want ambulance crews to revive you if your heart or breathing stops, you and your physician (**or** nurse practitioner **or** physician assistant) must both complete and sign this part.

Instructions for Part 7:

- If I stop breathing or my heart stops, I do not want the Emergency Medical Services (ambulance crews) to try to revive me. My physician (**or** nurse practitioner **or** physician assistant) and I have discussed this and signed the special form on the next page. I understand that this decision will not prevent me from receiving other emergency care, or comfort care from health care workers before I die.
- I understand that the form goes into effect when I have signed it **AND** it is signed by my physician (**or** nurse practitioner **or** physician assistant).
- I understand that this directive will not be followed unless my family, caretaker or I give the signed form on the next page to Emergency Medical Services (ambulance crews), and that it is solely my responsibility to make sure they see it.
- I understand that I should carry the signed form with me unless I wear health alert jewelry, such as MedicAlert, that also tells people that I do not want to be revived if my heart or breathing stops (Please call Maine Emergency Medical Services at 207-626-3860 to see if there are other Maine EMS approved health alert jewelry companies).
- I understand that if any health care provider has any doubts about what I want, they will try to restart my heart or breathing.
- I understand that I may revoke this directive at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry. I can also tell the ambulance crews that I have changed my mind.
- I understand that should I change my mind, it is my responsibility to tell my physician (**or** nurse practitioner **or** physician assistant) and other people who have copies of the signed form.
- If I want my agent to make this decision later, my agent should take the form available at: <http://www.maine.gov/dps/ems> to my physician (**or** nurse practitioner **or** physician assistant) when it is time to make the decision.

If you complete and sign this section, put the original in a safe place and be sure to give copies to ambulance crews, your family, your caregivers, and your physician.

DO-NOT-RESUSCITATE (DNR) DIRECTIVE

This section is optional. If you do not want ambulance crews to revive you if your heart or breathing stops, you **and** your physician (**or** nurse practitioner **or** physician assistant) must complete and sign this form.

FOR PATIENT TO COMPLETE after consultation with his or her health care provider:

In the event that my heart or breathing stops and I am unable to speak for myself, I, _____ (printed name) direct that no efforts be taken to restart my heart or breathing and that Emergency Medical Services (ambulance crews) if notified, honor my directive. I have come to this decision after considering my condition and prognosis and the potential risks, burdens and benefits of refusing efforts to restart my heart or breathing.

I understand that I may change my mind at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry, such as MedicAlert. I will also tell my physician (**or** nurse practitioner **or** physician assistant) and other caregivers if I change my mind.

I understand that this form is not valid until my physician (**or** nurse practitioner **or** physician assistant) **and** I have signed it.

I understand that in a hospital, nursing home, hospice or home health setting, federal law requires that my physician must include a specific DNR order in my medical record or plan of care, even if we have both signed this form.

No expiration date **OR** Expires on _____

Patient Signature

Date Signed

FOR PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER TO COMPLETE:

By my signature I affirm that:

(i) After meeting with this patient and discussing this decision, I am satisfied that the patient understands the potential risks, burdens and benefits of refusing resuscitative interventions in light of the patient's medical condition; and (ii) I believe that the patient has made a voluntary informed decision about resuscitation and I agree to comply with that decision. I will tell any health care providers providing care under my authority to comply with this decision.

Signature and license level (MD, DO, PA or NP)

Date Signed

Printed Name

Telephone Number

THIS FORM IS ENDORSED BY MAINE EMERGENCY MEDICAL SERVICES



144 State Street, Portland, Maine 04101
207-879-3000
www.mercyhospital.org