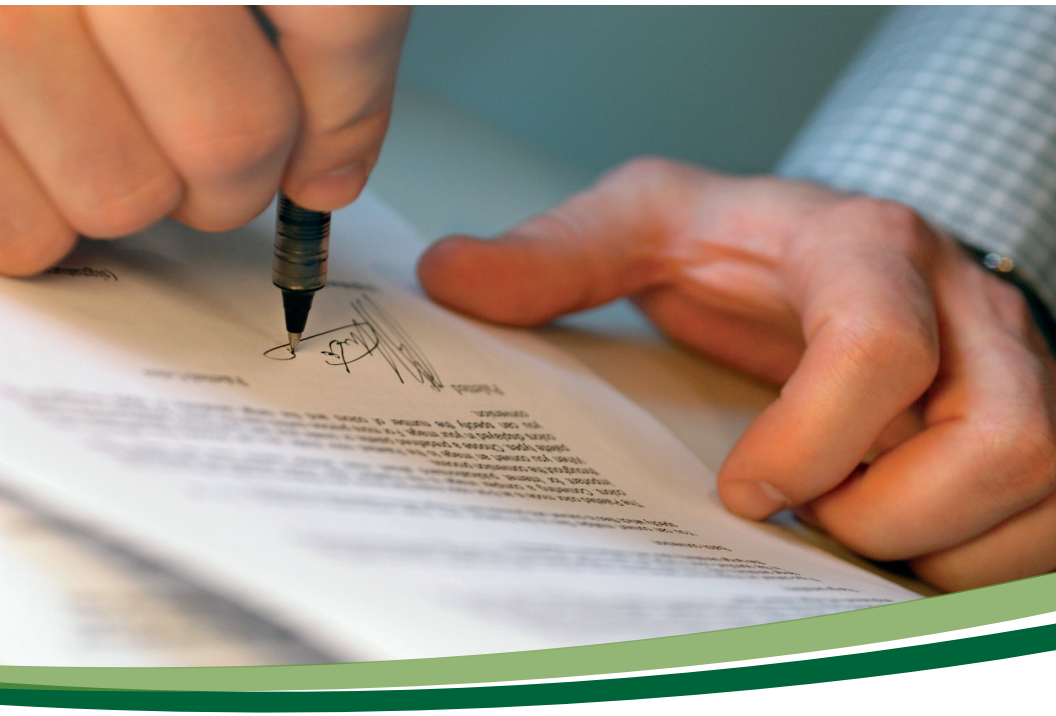
Putting it in Writing

A Guide to Advance Directives



THE
University of Vermont
HEALTH NETWORK
Champlain Valley Physicians Hospital

Putting it in Writing

Because of illness or injury people are sometimes unable to talk to a doctor and decide about treatment for themselves. You may wish to plan in advance to make sure that your wishes about treatment will be followed should you become unable to decide for yourself. In New York State, appointing someone you can trust to decide about treatment if you become unable to decide for yourself is the best way to protect your treatment wishes and concerns.

You have the right to appoint someone to decide for you by filling out a form called a Health Care Proxy. A copy of the form and information about the Health Care Proxy is available from your health care provider. If you have no one you can appoint or don't want to appoint someone, you can also give specific instructions about treatment in advance. Those instructions can be written and are often referred to as a Living Will.

It's in your best interest to choose someone you trust completely. You then need to talk with that person about your specific health care wishes. The person you choose will be the person who talks with the doctor and makes decisions they believe you would want. The only time your Health Care Proxy agent will speak for you and make decisions is when you are unable to do so for yourself. Some individuals may want to leave specific instructions even though they have discussed their wishes at length with their representative. If you feel this is necessary, those instructions can be documented in a Living Will, in the space provided on the Health Care Proxy, or in some other manner. The most important thing is to be sure you discuss your wishes in detail with your Health Care Proxy Agent.

AT THE UNIVERSITY OF VERMONT HEALTH NETWORK – CHAMPLAIN VALLEY PHYSICIANS HOSPITAL

The University of Vermont Health Network – Champlain Valley Physicians Hospital has adopted an Advanced Directives policy to ensure that medical treatment decisions correspond with the wishes of our patients and comply with current ethical and clinical guidelines and applicable state and federal laws.

Upon your admission to CVPH, you were asked if you had a completed Advanced Directive. If your answer was yes, a copy of your Advanced Directive is placed in your Medical Record. Ask your nurse if you currently don't have an Advanced Directive in place but would like to complete one.

You may revoke your Advanced Directive at any time by indicating your new wishes to your physician, showing an intention to revoke it to any health care professional or by creating a new directive.

Questions and Answers

DO I NEED LEGAL ASSISTANCE TO APPOINT A HEALTH CARE AGENT?

No. Attorneys need not be involved. All you need to do is complete a health care proxy form as directed and sign it along with two other witnesses. The witnesses must be over the age of 18.

WHO CAN BE MY HEALTH CARE AGENT?

Anyone at least 18 years of age can be a health care agent. He or she needs to be someone you trust and they should be familiar with your moral and religious beliefs.

The most important thing is that you talk with your health care agent about your health care wishes, and make sure you give your agent a copy of the proxy form.

WHAT DECISIONS CAN MY HEALTH CARE AGENT MAKE?

Unless you limit your health care agent's authority, your agent will be able to make any treatment decision that you could have made if you were able to decide for yourself. Your agent can agree that you should receive treatment, choose among different treatments, and decide that treatments should not be provided, in accord with your wishes and interests. If your health care agent is not aware of your wishes about artificial nutrition and hydration (nourishment and water provided by feeding tubes), he or she will not be able to make decisions about these measures. Artificial nutrition and hydration are used in many circumstances, and are often used to continue the life of patients who are in a permanent coma.

MAY I USE THE HEALTH CARE PROXY FORM TO EXPRESS MY WISHES ABOUT ORGAN AND/OR TISSUE DONATION?

Yes. Use the optional organ and/or tissue donation section on the Health Care Proxy form. You may specify that your organs and/or tissues be used for transplantation, research, or educational purposes. Any limitation(s) associated with your wishes should be noted in this section of the proxy.

CAN MY HEALTH CARE AGENT MAKE DECISIONS FOR ME ABOUT ORGAN AND/OR TISSUE DONATION?

No. The power of a health care agent to make health care decisions on your behalf ends upon your death. Noting your wishes on your Health Care Proxy form allows you to clearly state your wishes about organ and tissue donation.

Questions and Answers *continued*

CAN I HAVE MORE THAN ONE HEALTH CARE AGENT?

You can have one agent and an alternate agent. Your alternate agent will represent you if your agent is not available.

CAN I CHANGE MY HEALTH CARE AGENT?

Yes, you can change your health care agent if you wish. If you make this change, you'll need to fill out a new Health Care Proxy identifying your new agent. It will be important you send a copy of this new form to your primary care physician along with any facility that would have your Health Care Proxy on file.

Advance Directive Treatment Choices

Advance Directives can limit life-prolonging medical treatment when there is little or no chance of recovery. Medical treatment at the end of life usually falls into three main categories - life supporting, life sustaining and life enhancing.

Life Supporting

Life support uses CPR and machines to keep your heart and lungs going when they can no longer work on their own.

CPR

CPR is emergency treatment to restart the heart and lungs when your breathing or circulation stops. Sometimes doctors and patients decide in advance that CPR should not be provided, and the doctor gives the health care staff a Do Not Resuscitate Order (DNR Order). If your physical or mental condition prevents you from deciding about CPR, someone you appoint, your family members or others close to you, can decide. A brochure on CPR and your rights under New York DNR law is available. Ask your nurse for a copy.

RESPIRATORY THERAPY

A respirator or ventilator pumps oxygen into your lungs through a tube inserted into your windpipe. In some cases, normal breathing can never be restored.

Life Sustaining

Life sustaining care involves treatment or machines to prolong your life when your condition cannot be reversed or cured.

TUBE FEEDINGS

Tube feedings provide fluids through a feeding tube or an intravenous needle when you can no longer eat.

KIDNEY DIALYSIS

Kidney dialysis is a method of cleaning your blood by a machine when your kidneys no longer work properly. Chronic dialysis can prolong your life but cannot restore kidney function.

Life Enhancing

Life enhancing care keeps you comfortable until your death occurs naturally. There are no measures done artificially to prolong your life.

HOSPICE CARE

Hospice care is comfort care, such as oxygen, food and fluids by mouth and daily living physical care. Hospice care is given during the last stages of a terminal illness. Death is allowed to occur naturally.

PAIN MEDICATION

Pain medication, such as morphine, and other narcotics, can be given to keep you comfortable.

How Do I Complete the Health Care Proxy Form?

LINE (1)

Write your name and the name, home address and telephone number of the person you're selecting as your agent.

LINE (2)

Write the name, home address and telephone number of an alternative agent.

LINE (3)

If you wish to set an expiration date for your health care proxy form, you should write that date on this line. This form will remain valid indefinitely unless you set a date for its expiration.

LINE (4)

If you wish to limit your agent's authority in any way or have any instructions, you should indicate your wishes here. **If you do not state any limitations, your health care agent will be allowed to make all of your health care decisions,** including the decision to receive or refuse life sustaining treatment.

Optional Wording:
I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions (attach additional pages as necessary)

My agent knows my wishes including artificial nutrition and hydration (food, water, tube feedings, and IV's) and can make all decisions on my behalf.

If, after medical consultation between my physician and Proxy, it is found that I have a medical condition that is burdensome to my family and I will not live, please allow my Proxy to remove all life support, including nutrition and hydration.

How Do I Complete the Health Care Proxy Form? *continued*

LINE (5)

You must date and sign the proxy form. If you're unable to sign the form yourself, you may direct someone else to sign it in your presence. Be sure to include your address.

LINE (6)

If you wish to make an organ and/or tissue donation, complete this section. If you don't state your wishes or instructions on the form, it will be taken to mean that you do not wish to make a donation, or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

LINE (7)

Two witnesses, at least 18 years of age, must sign your proxy form. Your agent and alternate agent cannot act as a witness.

The heart and science of medicine.

FOR MORE INFORMATION

To find health information, or for convenient and secure access to your medical record through MyHealth Online, please visit **UVMHealth.org/CVPH** or call us at **(518) 561-2000.**

The University of Vermont Health Network
Champlain Valley Physicians Hospital
75 Beekman Street
Plattsburgh, NY 12901
(518) 561-2000

FORM NO. AD0028 (3/15)

UVMHealth.org/CVPH

THE University of Vermont HEALTH NETWORK
Champlain Valley Physicians Hospital

HEALTH CARE PROXY

(1) I, _____ hereby appoint

_____

(name, home address and telephone number)

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect when and if I become unable to make my own health care decisions.

(2) OPTIONAL: ALTERNATE AGENT

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint

_____

(name, home address and telephone number)

_____

_____

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) Unless I revoke it or state an expiration date or circumstances under which it will expire, this proxy shall remain in effect indefinitely.

(Optional: if you want this proxy to expire, state the date or conditions here) This proxy shall expire (specify date or conditions)

_____

_____

(4) OPTIONAL: I direct my health care agent to make health care decisions according to my wishes and limitations, as he or she knows or as stated below. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here. See the instruction sheet for examples)*

_____

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration *(nourishment and water provided by feeding tube and intravenous line)* your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

(5) YOUR IDENTIFICATION (please print)

Your Name _____

Your Signature _____ Date _____

Your Address _____

(6) OPTIONAL: ORGAN AND/OR TISSUE DONATION

I hereby make an anatomical gift, to be effective upon my death of (check any that apply)

☐ Any needed organs and/or tissues

☐ The following organs and/or tissues _____

_____

☐ Limitations _____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

Your Signature _____ Date _____

(7) STATEMENT BY WITNESSES *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate)*

I declare that the person who signed this document is personally known to be and appears to be of sound mind and acting of his or her own free will. He or she signed (or asked another to sign for him or her) this document in my presence.

Date _____	Date _____
Name of Witness 1	Name of Witness 2
(print) _____	*(print)* _____
Signature _____	Signature _____
Address _____	Address _____
_____	_____