

# ADVANCE HEALTH CARE DIRECTIVE

of \_\_\_\_\_

## PREAMBLE

*As a Catholic, I believe that life is a precious gift from God, and that He alone has dominion over human life. God has made us stewards of life. Our stewardship requires the use of every reasonable means to protect and preserve life and forbids any action intended to end our own lives or those of other innocent human beings. I believe that euthanasia and all forms of suicide and assisted suicide are never morally permissible. For purposes of this ADVANCE DIRECTIVE, euthanasia is defined as an action or omission which of itself or by intention will cause my death for the purpose of eliminating suffering.*

## PART I. INSTRUCTIONS FOR HEALTH CARE DECISIONS

I understand that I have a legal right to make my own decisions about my health care. I am of sound mind and am not under or subject to duress, fraud, or undue influence. I am a competent adult person who understands and accepts the consequences of these instructions.

There may come a time when I am unable, due to physical or mental incapacity, to express my own health care decisions. In these circumstances, those caring for me will need to turn to someone who knows my values and health care intentions. I am, therefore, signing the attached ADVANCE HEALTH CARE DIRECTIVE to provide the guidance and authority needed to implement my wishes.

This ADVANCE HEALTH CARE DIRECTIVE shall take effect in the event that my attending physician determines that I lack sufficient capacity to make or communicate decisions about my health care. The determination of my medical condition must be confirmed by a second physician with appropriate expertise. To inform those responsible for my care of my specific intentions, I direct that the following health care decisions be implemented:

### Medical Treatment Decisions

I desire that all *ordinary* medical interventions (those that are useful and offer a reasonable hope of benefit without causing excessive burdens) be used in my treatment and care. Unless there is a particular reason for doing otherwise, I wish to forgo all *extraordinary* means (those that are futile or that are likely to cause burdens that are disproportionate to any expected benefits). In all circumstances, I oppose any act or omission that of itself or by intention will cause my death, even for the purpose of eliminating suffering. I direct that

all decisions regarding my medical treatment and care be made in accord with Catholic moral teachings as set forth in such documents as the following:

*Declaration on Euthanasia (Congregation for the Doctrine of the Faith, 1980);*

*Patients in a "Permanent" Vegetative State (Pope John Paul II, March 20, 2004);*

*United States Conference of Catholic Bishops, Ethical and Religious Directives for Catholic Health Care Services, 5<sup>th</sup> edition, 2009 or edition current at the time decisions are being made.*

*Responses to Certain Questions Concerning Artificial Nutrition and Hydration (Congregation for the Doctrine of the Faith, 2007).*

### **Pain Relieving Medication**

If my condition includes physical pain, I wish to receive pain-relieving medication in dosages sufficient to manage the pain. If I am dying and pain management should require increasingly greater dosages of medication, I direct that they be increased in increments sufficient to manage the pain, even if this increase should hasten my death. **However, pain medication should not be given to me for the purpose of hastening my death.**

### **Food and Fluids (Nutrition and Hydration)**

I wish to receive nutrition and hydration, even if its supply is medically assisted, as long as it is effectively capable of sustaining my life. Even if I am permanently unconscious, medically assisted nutrition and hydration should be continued until it is deemed futile (i.e. no longer able to sustain my life) or it imposes disproportionate burdens on me (i.e. serious risk, excessive pain, excessive expense on my family or the community). If my death is truly imminent, or if my body is unable to assimilate foods and fluids, or if there is some other serious medical problem preventing nourishment, the medically assisted supply of nutrition and hydration may be considered unnecessary and discontinued.

### **End of Life**

I ask that if I fall terminally ill, I be told of this circumstance so that I might prepare myself for death. I request that I be attended by a Catholic priest and I be given the opportunity to receive the Sacraments of Penance, the Anointing of the Sick, and the Eucharist. If I should be unconscious or otherwise incompetent, I wish the priest to offer the prayers for the dying, and, if appropriate, to administer the Sacrament of the Anointing of the Sick, including Viaticum.

**FURTHER COMMENTS (if none, so indicate)**

I also note the following:

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**PART II. POWER OF ATTORNEY FOR HEALTH CARE**

*Your agent may make any health care decision that you could have made while you had the capacity to make health care decisions. You may appoint an alternate agent to make health care decisions if the first agent is not willing, able or reasonably available to make health care decisions for you. Unless the persons you name as agent and alternate agent are related to you by blood, neither may own, operate or be employed by any residential long-term care institution where you are receiving care.*

**A. DESIGNATION OF AGENT:** I hereby designate the following person as my agent to make health care decisions for me. If he/she is not living, willing or able, or reasonably available to make health care decisions for me, then I designate the next listed person as my alternate agent to make health care decisions for me.

\_\_\_\_\_  
(Name / Relationship of individual you choose as agent)  
(Address)\_\_\_\_\_  
(City)\_\_\_\_\_ (State)\_\_\_\_\_ (Zip)\_\_\_\_\_  
(Phone) Home\_\_\_\_\_ (Work)\_\_\_\_\_ (Cell)\_\_\_\_\_

\_\_\_\_\_  
(Name / Relationship of individual you choose as first alternate agent)  
(Address)\_\_\_\_\_  
(City)\_\_\_\_\_ (State)\_\_\_\_\_ (Zip)\_\_\_\_\_  
(Phone) Home\_\_\_\_\_ (Work)\_\_\_\_\_ (Cell)\_\_\_\_\_

\_\_\_\_\_  
(Name / Relationship of individual you choose as second alternate agent)  
(Address)\_\_\_\_\_  
(City)\_\_\_\_\_ (State)\_\_\_\_\_ (Zip)\_\_\_\_\_  
(Phone) Home\_\_\_\_\_ (Work)\_\_\_\_\_ (Cell)\_\_\_\_\_

**B. AGENT’S AUTHORITY:** If I am not in a condition to make decisions regarding my health care, I grant to my agent full authority to make such decisions for me; provided that, in exercising this authority, my agent shall follow my intentions as stated in this document or otherwise known to my agent. Accordingly, my agent is authorized as follows:

- 1) To consent to, refuse, or withdraw consent to any and all types of medical treatment, (including CPR), to direct the issuance of a DNR order, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function that have become useless or extraordinary;
- 2) To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;
- 3) To authorize my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service;
- 4) To contract for any health care related service or facility on my behalf, without my agent incurring personal financial liability for such contracts;
- 5) To hire and fire medical, social service, and other support personnel responsible for my care; and
- 6) To authorize, or refuse to authorize, any medication or procedure intended to relieve pain directly (even though such use may lead to physical damage, addiction, or hasten the moment of my death as unintended possible side-effects).
- 7) To authorize Anatomical Gifts of any of my body parts for any purpose authorized by law.

**C. WHEN AGENT’S AUTHORITY BECOMES EFFECTIVE:**

My agent’s authority becomes effective when my attending physician determines I lack the capacity to make my own health care decisions.

**D. AGENT’S OBLIGATION:**

My agent shall make health care decisions for me in accordance with the instructions I give in Part I of this form and my other intentions to the extent known to my agent. To the extent my intentions are unknown, health care decisions by my agent shall conform as closely as possible to what I would have done or intended under the circumstances. If my agent is unable to determine what I would have done or intended under the circumstances, my agent will make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest my agent shall at all times consider my Catholic religious values.

**E. AUTHORIZATION AND CONSENT UNDER HIPAA:** This ADVANCE HEALTH CARE DIRECTIVE shall constitute my direct authorization and consent under the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations thereunder

("HIPAA"). In addition, I hereby waive all rights to privacy under all federal and state laws and designate my agent as my personal representative, within the meaning of HIPPA, for the purpose of requesting, receiving, using, disclosing, amending or otherwise having access to my personal, individually identifiable health information. I hereby authorize any health care provider to release to my agent or to any person designated by my agent, all medical records of whatever nature, mental health records, billing statements, radiological films, pathology material, photographs, videos, and other information concerning me. This ADVANCE DIRECTIVE also authorizes any health care provider to speak to and disclose orally, to my agent and any person designated by my agent, any information relating to my diagnosis, care, treatment, prognosis, and opinions with respect to me. It is my express intention that, to the greatest extent permitted by law, the authorization and consent provided herein shall be effective for so long as this ADVANCE DIRECTIVE is effective.

**F. EFFECT OF COPY:**

A copy of this form has the same effect as the original.

**G. EXPIRATION DATE:**

This ADVANCE HEALTH CARE DIRECTIVE shall have no expiration date. However it can be revoked or superseded by me at any time.

**H. OUT OF STATE APPLICATION**

I intend that this ADVANCE HEALTH CARE DIRECTIVE be honored in any jurisdiction to the extent allowed by law.

**STATEMENT OF WITNESSES (If not notarized below)**

SIGNED and DECLARED by the above-named declarant as and for his/her written declaration in our presence, who in his/her presence, at his/her request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state:

- A. The Declarant is mentally competent.
- B. That neither of us is prohibited by law from being a witness.
- C. Neither of us:
  - 1) Is related to the declarant by blood, marriage or adoption;
  - 2) Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the executing of the advance health care directive, is so entitled by operation of law then existing;
  - 3) Has, at the time of the execution of the advance health care directive, a present or inchoate claim against any portion of the estate of the declarant;
  - 4) Has a direct financial responsibility for the declarant's medical care;
  - 5) Has a controlling interest in or is an operator or an employee of a health care institution in which the declarant is a patient or resident;
  - 6) Is under eighteen years of age.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
(Signature of Declarant)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zip Code)

WITNESS:

\_\_\_\_\_ (Print Name)

\_\_\_\_\_ (Address)

\_\_\_\_\_ (City, State, Zip Code)

\_\_\_\_\_  
(Signature of Witness) (Date)

WITNESS:

\_\_\_\_\_ (Print Name)

\_\_\_\_\_ (Address)

\_\_\_\_\_ (City, State, Zip Code)

\_\_\_\_\_  
(Signature of Witness) (Date)



**NOTARIZATION**

*(Notarization is recommended, especially for those who might travel to other states, but it is not required.)*

Notary Acknowledgment.

State of \_\_\_\_\_

County of \_\_\_\_\_ ss.

On \_\_\_\_\_, 20\_\_\_\_, before me, the undersigned Notary Public, personally appeared \_\_\_\_\_, known to me or satisfactorily proven to be the person whose name is subscribed to the above ADVANCE HEALTH CARE DIRECTIVE as the Principal, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the Principal appears to be of sound mind and not under or subject to duress, fraud, or undue influence.

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_