My Choices

Advance Directive for Health Care

_____ _____ _____

Print your full name, *Date of birth, and* *Social Security number.*

These directions apply only in situations when I am not able to make or communicate my health care choices directly. *[Put an X through any sections you are not completing at this time.]*

I. Health Care Representative (Power of Attorney for Health Care)

My Representative may make ALL health care decisions for me as authorized in this document and shall be given access to all my medical records. This appointment applies whether I am expected to recover or not.

I wish to appoint a Representative: ☐ Yes ☐ No *[Go to Part II.]*

A. Primary Representative

I appoint _____ as my Representative.
Print Representative's Full Name

Representative's Address _____

City_____ State_____ Zip_____

Home Phone _____ Work Phone_____

My Representative's authority is effective when I cannot make health care decisions or communicate my wishes. I may revoke this authority at any time I regain these abilities (unless my attending physician and any necessary experts determine I am not capable of making decisions in my own best interest).

If, for any reason, I should need a guardian of my person designated by a court, I nominate my Representative, or Alternate Representative(s), named below.

B. Alternate Representatives

If: 1) I revoke my Representative's authority; **or**
2) My Representative becomes unwilling or unable to act for me; **or**
3) My Representative is my spouse and I become legally separated or divorced,

I name the following person(s) as alternates to my Representative in the order listed.

1._____
Print Alternate Representative's Full Name

Address_____

City_____

State_____ Zip _____

Home Ph_____ Work_____

2._____
Print Alternate Representative's Full Name

Address _____

City_____

State_____ Zip_____

Home Ph_____ Work_____

_____

Print your full name.

II. Terminal Conditions (Living Will)

I provide these directions in accordance with the Montana Rights of the Terminally Ill Act. These are my wishes for the kind of treatment I want **if I cannot communicate or make my own decisions**. These directions are **only valid if BOTH** of the following two conditions exist. **IF**:

1) I have a terminal condition;

AND

2) In the opinion of my attending physician, I will die in a relatively short time without life sustaining treatment which only prolongs the dying process.

I authorize my Representative, if I have appointed one, to make the decision to provide, withhold, or withdraw any health care treatment.

General Treatment Directions *[Check the boxes that express your wishes.]*

- ☐ I provide no directions at this time.
- ☐ I direct my attending physician to **withdraw or withhold treatment that merely prolongs the dying process**.

  I further direct that: *[Check all boxes that apply.]*
  - ☐ Treatment be given **to maintain my dignity, keep me comfortable, and relieve pain even if it shortens my life**.
  - ☐ If I **cannot drink, I do not want to receive fluids** through a needle or catheter placed in my body unless for comfort.
  - ☐ If I **cannot eat, I do not want a tube** inserted in my nose, mouth, or surgically placed in my stomach to give me food.
  - ☐ If I have a **serious infection, I do not want antibiotics** to prolong my life. Antibiotics may be used to treat a painful infection.

- ☐ I have attached additional directions regarding medical treatment to this form.
- ☐ I have **not** attached additional directions to this form at this time.

III. I Have a Chronic Illness or Serious Disability (*Optional*)

My chronic illness or disability can complicate an acute illness, but should not be misinterpreted as a terminal condition.

A. Diagnosis: _____

B. Consult my physician. *[Name, phone]* _____

C. Special directions. *[Use additional pages if necessary.]* _____

_____

_____

_____

_____

Witness and Notary on Page 3

IV. Signing, Witnessing This Advance Directive

A. Your Signature *[Ask two people to watch you sign and have them sign below. If you can, it's best to sign this document in front of a Notary Public.]*

1. I revoke any prior health care advance directive or directions.
2. This document is intended to be valid in any jurisdiction in which it is presented.
3. A copy of this document is intended to have the same effect as the original.
4. Those who act as I have directed in this document shall be free from legal liability for having followed my directions.
5. If my attending physician is unwilling or unable to comply with my wishes as stated in this document, I direct my care be transferred to a physician who will.

I sign this document on the_____day of _____, 20_____.

_____

Signature *Print Full Name*

Address_____

City_____ State_____ Zip _____

Home Phone _____ Work Phone_____

B. Ask Your Witnesses to Read and Sign

I declare that the person who signed this document is personally known to me, and has signed these health care advance directives in my presence, and appears to be of sound mind and under no duress, fraud, or undue influence.

As a witness, I am **NOT**:

- The person appointed as Representative by this document;
- Financially responsible for this person's health care;
- Related to this person by blood, marriage, or adoption; and
- To the best of my knowledge, entitled to inherit any part of this person's estate under a will now existing or by operation of law.

1._____ 2. _____

Signature *Date* *Signature* *Date*

Name_____ Name_____

Address_____ Address _____

City _____ City_____

State_____ Zip_____ State_____ Zip_____

C. Notarizing This Document *(Optional, but recommended)*

STATE OF _____ COUNTY OF _____

On this _____ day of_____, 20_____, the said known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public within and for the State and County aforesaid, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.

_____

_____

Notary Public for the State of _____

Residing at _____

My commission expires: _____

See Page 4 for Special Directions

V. Special Directions

A. Spiritual Preferences

My religion: _____ My faith community: _____

Contact person:_____ I would like spiritual support. ☐ Yes ☐ No

B. Where I would like to be when I die: ☐ My home ☐ Hospital ☐ Nursing home

☐ Other:_____

C. Donation of Organs at My Death

- ☐ **I do <u>not</u> wish to donate** any of my body, organs, or tissue.
- ☐ I wish to donate **my entire body**.
- ☐ I wish to donate **only** the following: *[Check all that apply.]*
  - ☐ Any organs, tissues, or body parts ☐ Heart ☐ Kidneys ☐ Lungs
  - ☐ Bone marrow ☐ Eyes ☐ Skin ☐ Liver ☐ Other(s)

D. After Death Care: *[Care of my body, burial, cremation, funeral home preference]*

_____

E. Additional Directions: *[Use additional pages if necessary.]* _____

_____

Signature _____ Date _____

F. Distributing This Advance Directive

I plan to deposit this Advance Directive in the Choices Bank: ☐ Yes ☐ No

I plan to send copies of this document to the following people or locations:

Physician:_____

Name_____

Address_____

City_____ State_____ Zip_____

Home Ph_____ Work_____

Family Member: Relationship_____

Name_____

Address_____

City_____ State_____ Zip_____

Home Ph_____ Work_____

Hospital:_____

Name_____

Address_____

City_____ State_____ Zip_____

Phone_____

Clergy:_____

Name_____

Address_____

City_____ State_____ Zip_____

Home Ph_____ Work_____

My Choices was created by the Advance Care Planning Task Force of the Life's End Institute: Missoula Demonstration Project (406/728-1613). Members of this task force represent Missoula hospitals, home care agencies, hospice, long-term care facilities, Missoula Aging Services, Coalition of Montanans Concerned with Disabilities, AARP, public health, physicians, nurses, physician assistants, social workers, emergency medical technicians, attorneys, and clergy. Version 3.1. A copy of *My Choices* can be printed from www.choicesbank.org.

Choices Bank

Deposit & Release Form

Your advance directive anytime, anywhere

www.choicesbank.org

PO Box 8485, Missoula, MT 59807-8485 • (406) 329-2707

Please Print Clearly

Name_____Date of Birth_____

Address_____

_____

Social Security #_____Driver's License #_____

Mother's Maiden Name (LAST NAME ONLY)_____

Received by_____Date Received_____

Pick your level of privacy. In either level, your health care providers can view your advance directive with or without the information on the wallet card we will send you.

❑ Standard privacy: If the information on my wallet card is unavailable, my advance directive can be viewed by people who enter my name, birth date, social security number, and mother's maiden name.

❑ Higher privacy: Only people who have the information from my wallet card and my health care providers can view my advance directive.

Request to Deposit Advance Directive in the Choices Bank and Release to Health Care Professionals Providing Treatment

I request that my most recently signed advance directive, which I am now presenting, be deposited in the Choices Bank. I request that it be made available for medical purposes only to health care professionals directly involved in my medical treatment. I understand I will receive a Choices Bank wallet card in the mail. I also understand that no one other than my health care providers or me will have access to my advance directive in the Choices Bank unless I choose the standard privacy level above or I provide the information contained on this wallet card to other people. The Choices Bank has adopted a privacy and security policy that governs all access and maintains my information in a confidential and secure manner. I understand I am entitled to review this policy prior to signing this release. The Choices Bank reserves the right to change this policy and will provide any revisions on its Web site at **www.choicesbank.org** or through this deposit location.

My signature on this document is required to complete the Choices Bank deposit process. I may update this document at anytime by depositing a more recent advance directive in the Choices Bank and signing a new document. I may also revoke this document if I remove my advance directive from the Choices Bank by following the process described on the Choices Bank Web site or by staff at this deposit location. Otherwise, this document remains in effect as long as my advance directive is in the Choices Bank.

Signature_____Date_____

If you are not the signer of the advance directive being deposited, and you have legal authority to make health care decisions for the signer, please show proof of this authority, print your name, and check the source of your authority.

Source of Authority (Check one box)

❑ Power of attorney

Printed Name_____ ❑ Court-appointed guardian