

Advance Directives

Important information on health care decision-making: You Have the Right to Decide

The documents provided in this package are being presented to you in accordance with the Federal Patient Self-determination Act, the Health Care Advance Directives Statute of Florida, and as a public service of Lee Memorial Health System.

**LEE MEMORIAL
HEALTH SYSTEM**

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Frequently Asked Questions Concerning Advance Directives

WHO NEEDS TO BE CONCERNED ABOUT ADVANCE DIRECTIVES?

All adult patients (age 18 years and older) should understand advance directives. Federal law requires certain facilities, including hospitals, nursing homes and home health agencies provide written information about an individual's rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Further, those facilities must document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive. Every adult person who becomes a patient in Lee Memorial Health System facilities should be asked whether they have written an advance directive. Advance directives are not required to receive care in Lee Memorial Health System, but are provided to you to be able to document your wishes concerning treatment.

WHY DOES LEE MEMORIAL PROVIDE THIS INFORMATION?

The United States Congress passed a law in 1990 called the "Patient Self-Determination Act". This law requires that all health care organizations provide written information to patients regarding their rights to make decisions about their own medical care. This includes the right to accept or refuse medical or surgical treatment.

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is a set of instructions you have prepared regarding your medical care. They may describe what treatment you do or do not want and serve to convey your wishes to the medical team in the event you are not able to give directions yourself.

WHO CAN BE A WITNESS TO A LIVING WILL?

Generally, any adult can be, but a spouse or blood relative can be only ONE of the witnesses; the second witness should be someone who is not related to you. The person you have named as your surrogate should not be one of the witnesses.

WHAT IS A LIVING WILL?

A living will contains specific instructions about what you want done regarding withholding or withdrawing life-prolonging procedures in the event you have a terminal condition, an end-stage condition, or are in a persistent vegetative state.

WHAT IS A DESIGNATION OF HEALTH CARE SURROGATE (DHCS)?

A DHCS is a document you sign appointing a person (surrogate) you trust to make health care decisions for you if you are temporarily or permanently unable to make health care decisions for yourself. It is important you talk with your surrogate and let the surrogate know your wishes about your medical care and treatment, so that your surrogate will make the decisions based upon your desires.

WHEN DOES MY LIVING WILL OR OTHER ADVANCE DIRECTIVE ACTUALLY GO INTO EFFECT?

Your physician, after evaluating your condition, will call in another physician for a second opinion. If both determine that you have a terminal condition, an end-stage condition, or a persistent vegetative state, your living will goes into effect. If you have designated a surrogate and it is determined by your physician that you do not have the “capacity”, or ability, to make your own decisions, then your surrogate would be asked to provide consent for you.

WHAT IF I HAVE NOT MADE AN ADVANCE DIRECTIVE OR CANNOT SIGN MY NAME ON A LIVING WILL?

You can give verbal instructions to your physician and family. However, it is more helpful for you to put your wishes in writing.

WHAT IF I CHANGE MY MIND AND WANT TO DELETE ALL OR PART OF MY LIVING WILL?

Your advance directive can be revoked at any time by doing any of the following things: a) signing a written statement saying that you revoke it; b) physically tearing up the directive or have someone else tear it up in your presence; c) orally expressing that you revoke it; d) executing another advance directive that is different than the previous one. The most important thing to remember is to tell your doctor, family or friends what you want.

CAN MY LIFE INSURANCE COMPANY CANCEL MY LIFE INSURANCE FOR SAYING I WANT LIFE SUPPORT WITHHELD OR WITHDRAWN?

No. Florida law states that no policy of life insurance will be invalidated by you making these choices. Also, you cannot be required to make an advance directive as a condition for getting insurance or being admitted to a hospital.

I SIGNED A LIVING WILL IN ANOTHER STATE. IS IT VALID HERE?

Normally, yes! Florida will recognize an advance directive executed in another state provided that it meets Florida's state requirements.

WHERE SHOULD I KEEP MY ADVANCE DIRECTIVE?

Your advance directive is your "voice" and should serve to give your instructions if you cannot. It is important that it be in an accessible place and that your surrogate, family and physician all have a copy of it. You should also bring a copy with you each time you are admitted to the hospital, or ask someone to bring it for you.

WHERE CAN I GET AN ADVANCE DIRECTIVE?

There is a form included in this booklet that you are free to use. There are other versions of living wills available. This one is the example provided in Florida Statutes. You may use another version of a living will, but it may be advisable to make sure that it meets Florida law requirements.

DO I NEED A LAWYER TO MAKE A LIVING WILL OR DESIGNATE A HEALTH CARE SURROGATE?

No. You can execute a living will or health care surrogate designation without a lawyer. However, if you need to prepare documents related to financial decision-making, such as a Durable Power of Attorney, you would be wise to ask for the assistance of an attorney. The information in this packet is related to health care decision-making.

We, at Lee Memorial Health System, hope that this booklet has helped answer questions about living wills and advance directives. However, if you have further questions and would like more assistance, please feel free to call us at:

343-2940—Medical Social Work, Department of Care Management

343-5199—Spiritual Services Department

424-3765—Older Adult Services

432-3450—HealthPark Care & Rehabilitation Center Social Services

343-2000—Guest Services

Living Will

(Please print your name)

(A life-prolonging procedure means any medical procedure, treatment, or intervention, including artificially provided sustenance and hydration, which sustains, restores or supplants a spontaneous vital function.)

(You should give your physician, family members or a close friend a copy of the document.)

(You may wish to give special consideration to cardiopulmonary resuscitation, ventilators for breathing, artificial tube feedings or fluids given by tubes, kidney dialysis, surgery, or antibiotics.)

YOU SIGN HERE

(If you are unable to sign, a witness must sign your name at your direction and in your presence).

WITNESS SIGN HERE

(Must be signed in the presence of two (2) witnesses, one of whom is neither a spouse nor a blood relative.)

WITNESS SIGN HERE

Declaration made this ____ day of _____, 20 ____

I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the following circumstances, and I do hereby declare:

If at any time I am incapacitated and:

- _____ I have a terminal condition, or
- _____ I have an end-stage condition, or
- _____ I am in a persistent vegetative state

Initial all that apply

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I would be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate the following person as my surrogate to carry out the provisions of this declaration.

Name _____

Address _____

City _____ State _____ Zip Code _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional instructions (optional):

Signed _____

Witness _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Witness _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Designation of Health Care Surrogate

Name _____

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

If my surrogate is unwilling or unable to perform his/her duties, I wish to designate as my alternate surrogate:

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

I fully understand that this designation will permit my designee to make health care decisions, except for anatomical gifts, unless I have executed an anatomical-gift declaration pursuant to law, and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional instructions (optional) _____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is:

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Signed _____ **Date** _____

Witness #1 _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Witness #2 _____

Address _____

City _____ State _____ Zip Code _____

Phone _____