

Pennsylvania Advance Health Care Directive

This form lets you have a say about how you want to be treated if you get very sick.

Download the LVHN Advance Care Planning Ebook - <http://education.lvh.com/advancecareplan/lvhn.html>

Important:

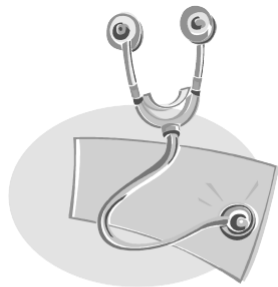
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This form has 3 parts. It lets you:



Part 1: Choose a medical decision maker.

A medical decision maker is a person who can make health care decisions for you if you are too sick to make them yourself.



Part 2: Make your own health care choices.

This form lets you choose the kind of health care you want.

This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.



Part 3: Sign the form.

It must be signed before it can be used.

You can fill out Part 1, Part 2, or both.

Fill out **only** the parts you want. Always sign the form in Part 3.
2 witnesses need to sign on page 11.

YOUR NAME: _____

If you only want to name a medical decision maker go to **Part 1** on page 3.

If you only want to make your own health care choices go to **Part 2** on page 6.

If you want both then fill out **Part 1 and Part 2**.

Always sign the form in **Part 3** on page 9.

2 witnesses need to sign on page 11.

What if I change my mind?

- s Fill out a new form.
- s Tell those who care for you about your changes.
- s Give the new form to your medical decision maker and doctor.



What if I have questions about the form?

Ask your doctors, nurses, social workers, friends or family to answer your questions. Lawyers can help too.



What if I want to make health care choices that are not on this form?

Write your choices on page 9.

Share this form and your choices with your family, friends, and medical providers.



Part 1

Choose your medical decision maker

The person who can make health care decisions for you if you are too sick to make them yourself.

Whom should I choose to be my medical decision maker?

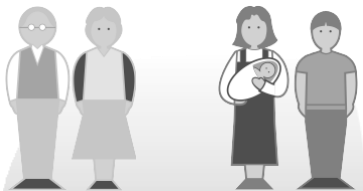
A family member or friend who:

- s is at least 18 years old
- s knows you well
- s can be there for you when you need them
- s you trust to do what is best for you
- s can tell your doctors about the decisions you made on this form



Your decision maker **cannot** be your doctor or someone who works at your hospital or clinic, unless he/she is a family member.

What will happen if I do not choose a medical decision maker?



If you are too sick to make your own decisions, a person will be chosen for you according to Pennsylvania law. This person may not know what you want.

What kind of decisions can my medical decision maker make?

Agree to, say no to, change, stop or choose:

- s doctors, nurses, social workers
- s hospitals, clinics, or where you live
- s medications, tests, or treatments
- s what happens to your body and organs after you die



Your decision maker will need to follow the health care choices you make in Part 2.

Other decisions your medical decision maker can make:

Life support treatments – medical care to try to help you live longer

§ CPR or cardiopulmonary resuscitation

cardio = heart pulmonary = lungs resuscitation = to bring back

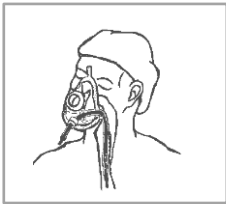


This may involve:

- pressing hard on your chest to keep your blood pumping
- electrical shocks to jump start your heart
- medicines in your veins

§ Breathing machine or ventilator

The machine pumps air into your lungs and breathes for you.
You are not able to talk when you are on the machine.



§ Dialysis

A machine that cleans your blood if your kidneys stop working.

§ Feeding Tube

A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.



§ Blood transfusions

To put blood in your veins.

§ Surgery

§ Medicines

End of life care – if you might die soon your medical decision maker can:



– call in a spiritual leader

– decide if you die at home or in the hospital

– decide where you should be buried



Show your medical decision maker this form.

Tell your decision maker what kind of medical care you want.

Your Medical Decision Maker



I want this person to make my medical decisions if I cannot make my own

first name ()	–	last name ()	–
home number		work number	relationship
street address	city	state	zip code

If the first person cannot do it, then I want this person to make my medical decisions. Also, if the first person is a spouse and you divorce, the doctors will turn to this person.

first name ()	–	last name ()	–
home number		work number	relationship
street address	city	state	zip code

Put an X next to the sentence you agree with.

- My medical decision maker can make decisions for me right after I sign this form.
- My medical decision maker will make decisions for me **only** after I cannot make my own decisions.

How do you want your medical decision maker to follow your healthcare wishes?
Put an X next to the **one** sentence you most agree with.

- Total Flexibility:** It is OK for my decision maker to change any of my medical decisions if my doctors think it is best for me at that time.
- Some Flexibility:** It is OK for my decision maker to change some of my decisions if the doctors think it is best. But, these are some wishes I never want changed:

- No flexibility:** I want my decision maker to follow my medical wishes exactly, no matter what. It is **not OK** to change my decisions, even if the doctors recommend it.

To make your own health care choices go to Part 2 on the next page.

If you are done, you must sign this form on page 9.

Part 2

Make your own health care choices

Write down your choices so those who care for you will not have to guess.

Think about what makes your life worth living.
Put an X next to **all** the sentences you most agree with.

My life is **only** worth living if I can:

- talk to family or friends
- wake up from a coma
- feed, bathe, or take care of myself
- be free from pain
- live without being hooked up to machines
- My life is always worth living no matter how sick I am
- I am not sure



If I am dying, it is important for me to be:

- at home in the hospital I am not sure

Is religion or spirituality important to you?

- no yes If you have one, what is your religion?

What should your doctors know about your religious or spiritual beliefs?

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.

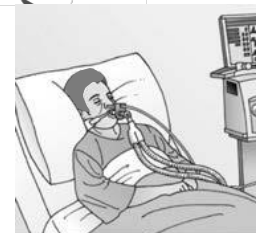
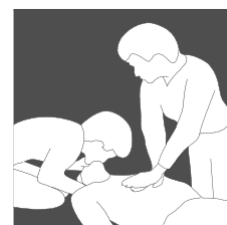
Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.

Please **read this whole page** before you make your choice.

Put an X next to the **one** choice you most agree with.

If I am so sick that I may die soon:

- Try all life support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, **I want to stay on life support machines** even if I am suffering.
- Try all life support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, **I do NOT want to stay on life support machines**. If I am suffering, I want to stop.
- I do not want life support treatments**, and I want to focus on being comfortable. I prefer to have a natural death.
- I want my **medical decision maker** to decide for me.
- I am not sure.



*If you are pregnant and become unable to make decisions: Pennsylvania law may require your doctor to give you life support treatments even if you have an advance directive.

If you want to write down medical wishes that are not on this form, go to page 9.

YOUR NAME: _____

Your doctors may ask about organ donation and autopsy after you die.
Please tell us your wishes.

Put an X next to the **one** choice you most agree with.

Donating (giving) your organs can help save lives.

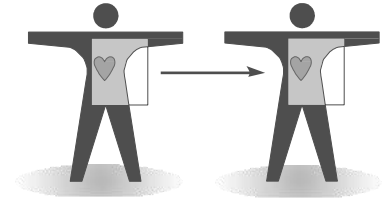
- I **want** to donate my organs.

Which organs do you want to donate?

any organ

only _____

- I **do not** want to donate my organs.
- I want my **decision maker** to decide.
- I am not sure.



An autopsy can be done after death to find out why someone died.
It is done by surgery. It can take a few days.

- I **want** an autopsy.
- I **do not** want an autopsy.
- I **only** want an autopsy if there are questions about my death.
- I want my **decision maker** to decide.
- I am not sure.



What should your doctors know about how you want your body to be treated after you die? Do you have funeral or burial wishes?

YOUR NAME: _____

What other wishes are important to you?

Part 3

Sign the form

Before this form can be used, you must:

- s sign this form if you are at least 18 years of age
- s have two witnesses sign the form



Sign your name and write the date.

sign your name / / date

print your first name print your last name

address city state zip code

Part 3 Witnesses



Before this form can be used you must have
2 witnesses sign the form

Your witnesses must:

- s be over 18 years of age
- s know you
- s see you sign this form

Your witnesses cannot:

- s be your medical decision maker
- s be your health care provider
- s work for your health care provider
- s work at the place that you live



Also, one witness cannot:

- s be related to you in any way
- s benefit financially (get any money or property) after you die

Witnesses need to sign their names on the next page.

Have your witnesses sign their names and write the date

By signing, I promise that _____ signed this form while I watched.
(name)

He/she was thinking clearly and was not forced to sign it.

I also promise that:

- s I know this person and he/she could prove who he/she was.
- s I am 18 years or older
- s I am not his/her medical decision maker
- s I am not his/her health care provider
- s I do not work for his/her health care provider
- s I do not work where he/she lives



One witness must also promise that:

- s) AM NOT RELATED TO HIM/HER BY BLOOD, MARRIAGE, OR ADOPTION
- s) WILL NOT BENEFIT FINANCIALLY (GET ANY MONEY OR PROPERTY) AFTER HE/SHE DIES

Witness #1

_____ / /
sign your name date

_____ print your first name print your last name

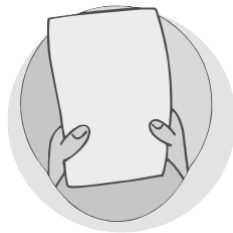
_____ address city state zip code

Witness #2

_____ / /
sign your name date

_____ print your first name print your last name

_____ address city state zip code



You are now done with this form.

Share this form with your family, friends, and medical providers.
Talk with them about your medical wishes

