佛蒙特州医疗预先指示

由佛蒙特州伦理网络制作

Vermont Advance Directive for Health Care

Prepared by the Vermont Ethics Network

CHINESE

解释和说明
EXPLANATION & INSTRUCTIONS

- 您有权：/ You have the right to:
  1. 当您不能自己做医疗决定时，让别人为您做决定。
     Name someone else to make health care decisions for you when or if you are unable to make them yourself.
  2. 说明您想要或不想要哪种医疗类型
     Give instructions about what types of health care you want or do not want.
- 重要的是与您最亲近的人以及您的医疗提供者谈论您的治疗目标、愿望和偏好。
  It is important to talk with those people closest to you and with your health care providers about your goals, wishes and preferences for treatment.
- 您可以使用本表格的全部，也可以使用其中的任何部分。例如，如果您只想在第一部分中选择一个代理，您可以只填写那部分，然后在适当的证人在场的情况下到第五部分签字。
  You may use this form in its entirety or you may use any part of it. For example, if you only want to choose an agent in Part One, you may fill out just that section and then go to Part Five to sign in the presence of appropriate witnesses.
- 只要有适当的见证，您也可使用另外的表格。关于心理医疗偏好的更多选择和信息，可在VEN网站www.vtethicsnetwork.org上找到更详细的表格。
  You are free to use another form so long as it is properly witnessed. More detailed forms providing greater options and information regarding mental health care preference can be found on the VEN website at www.vtethicsnetwork.org.

该表格的**第一部分**允许您指定一个人作为您的“**代理**”，以便在您无法或不愿意自己做决定时为您做医疗决定。您也可指定候补代理。您应该选择一个您信任的人，他会为您做一些艰难的决定。他们应该在您的价值观指导下为您做出选择，**并同意**作为您的代理。您可以填写预先指示表格，说明您的医疗偏好，*即使您没有确定代理*。如果没有代理，医疗提供者会尽力遵循您在预先指示中的指令，但指定一个人作为您的代理为您做出决定，将有助于医疗提供者和那些关心您的人在您的预先指示中没有详细说明的情况下，做出最好的决定。根据佛蒙特州的法律，如果您无法做决定，近亲将不会自动为您做决定。这就是为什么最好提前指定您选择的人。

Part ONE of this form allows you to name a person as your “**agent**” to make health care decisions for you if you become unable or unwilling to make your own decisions. You may also name alternate agents. You should choose someone you trust, who will be comfortable making what might be hard decisions on your behalf. They should be guided by your values in making choices for you **and agree** to act as your agent. You may fill out the Advance Directive form stating your medical preferences *even if you do not identify an agent*. Medical providers will follow your directions in the Advance Directive without an agent to their best ability, but having a person designated as your agent to make decisions for you will help medical providers and those who care for you make the best decisions in situations that may not have been detailed in your Advance Directive. According to Vermont law, next-of-kin will not automatially make decisions on your behalf if you are unable to do so. That is why it is best to appoint someone of your choosing in advance.

表格的第二部分让您陈述**治疗目标和愿望**。在某些情况下，您可以选择表达您希望接受、不接受或停止治疗的意愿。您还可以根据自己的价值观、健康状况或信仰写下任何额外或具体的愿望。

Part TWO of this form lets you state **Treatment Goals & Wishes**. Choices are provided for you to express your wishes about having, not having, or stopping treatment under certain circumstances. Space is also provided for you to write out any additional or specific wishes based on your values, health condition or beliefs.

表格的第三部分让您表达您对**治疗限制**的意愿。这些治疗包括心肺复苏、呼吸机、喂食管和抗生素。还有空间让您写下其它愿望。注：如果您不想使用心肺复苏、呼吸机、喂食管或抗生素，请与您的医生讨论，这名医生可以填写**DNR/COLST令**（不复苏/临床医生维持生命治疗令），以确保您不会得到您不想要的治疗，尤其是在紧急情况下。紧急医疗人员被要求为您提供拯救生命的治疗，除非他们签署了DNR/COLST令，明确了某些治疗限制。如果没有DNR/COLST令，紧急医疗小组将执行心肺复苏，因为他们没有时间咨询预先指示、您的家人、代理或医生。

Part THREE of this form lets you express your wishes about **Limitations of Treatment**. These treatments include CPR, breathing machines, feeding tubes, and antibiotics. There is space for you to write any additional wishes. NOTE: If you DO NOT want CPR, a breathing machine, a feeding tube, or antibiotics, please discuss this with your doctor, who can complete a **DNR/COLST order** (Do Not

Resuscitate/Clinician Order for Life Sustaining Treatment) to ensure that you do not receive treatments you do not want, especially in an emergency. Emergency Medical Personnel are required to provide you with life-saving treatment unless they have a signed DNR/COLST order specifying some limitation of treatment. If there is no DNR/COLST order the emergency medical team will perform CPR as they will not have time to consult an Advance Directive, your family, agent, or physician.

在此表格的第四部分，您可以表达您对**器官/组织捐赠的意愿，以及您对葬礼、下葬和**遗体处置**的偏好。**

Part FOUR of this form allows you to express your wishes related to **organ/tissue donation & preferences for funeral, burial and disposition** of your remains.

第五部分是签名。您必须在两名成年证人在场的情况下在表格上签名并注明日期。下列人士不得为证人：您的代理及候补代理；您的配偶或伴侣；父母；兄弟姐妹；孩子或者孙子。

您应将填妥的表格副本交给您的代理和候补代理、您的医生、您的家人以及您居住或可能接受治疗的任何医疗机构。请注意如果您的偏好有所更改，您的预先指示副本也可能更改。

我们还鼓励您将您的预先指示副本连同本文件末尾的注册协议表格发送到佛蒙特州预先指示登记处。

您有权在任何时候撤销本医疗预先指示的全部或部分内容，或替换本表格。如果您确实撤销了它，以前的所有副本都应该销毁。如果您做了更改，并向佛蒙特州预先指示登记处发送了一份原始文件的副本，请确保向他们发送一份新的副本或更改表格的通知，其中包含更新您的预先指示所需的信息。

Part FIVE is for signatures. You must sign and date the form in the presence of two adult witnesses. The following persons may not be witnesses: your agent and alternate agents; your spouse or partner; parents; siblings; children or grandchildren.

You should give copies of the completed form to your agent and alternate agent(s), to your physician, your family and to any health care facility where you reside or at which you are likely to receive care. Please note who has a copy of your Advance Directive so it may be updated if your preferences change.

You are also encouraged to send a copy of your Advance Directive to the Vermont Advance Directive Registry with the Registration Agreement Form found at the end of this document.

You have the right to revoke all or part of this Advance Directive for Health Care or replace this form at any time. If you do revoke it, all old copies should be destroyed. If you make changes and have sent a copy of your original document to the Vermont Advance Directive Registry, be sure to send them a new copy or a notification of change form with information needed to update your Advance Directive there.

您可能希望阅读*Taking Steps（采取步骤）*小册子，以帮助您思考并与您的代理或爱人讨论不同的选择和情况。

You may wish to read the booklet *Taking Steps* to help you think about and discuss different choices and situations with your agent(s) or loved ones.

*Taking Steps*的副本可从以下网站购买：

Copies of *Taking Steps* can be purchased from:

Vermont Ethics Network
61 Elm Street
Montpelier, VT 05602.
电话 (Tel) (802) 828-2909
传真 (Fax) (802) 828-2646
www.vtethicsnetwork.org

欲了解关于佛蒙特州预先指示登记处的信息，请访问：/ For information about the Vermont Advance Directive Registry visit:

VEN 网站：www.vtethicsnetwork.org
VEN website

或 / or

佛蒙特州卫生部的登记处网站：
Registry website at the Vermont Department of Health:

www.healthvermont.gov/vadr

佛蒙特州医疗预先指示

Vermont Advance Directive for Health Care

您的姓名 YOUR NAME | 出生日期 DATE OF BIRTH | 日期 DATE

地址 ADDRESS

城市 CITY | 州 STATE | 邮编 ZIP

第一部分：您的医疗代理
PART ONE: YOUR HEALTH CARE AGENT

当您不能或不愿意为自己做决定时，您的**医疗代理**可以为您做医疗决定。您应该选择一个您信任的人，一个理解您的意愿并同意作为您的代理的人。您的医疗提供者可能**不是**您的代理，除非他们是您的亲戚。在完成您的预先指示时，您的代理可能**不是**您所居住的养老院、医疗设施或康复设施的所有者、运营商、员工或合同工。

Your health care agent can make health care decisions for you when you are unable or unwilling to make decisions for yourself. You should pick someone that you trust, who understands your wishes and agrees to act as your agent. Your health care provider may **NOT** be your agent unless they are a relative. Your agent may **NOT** be the owner, operator, employee or contractor of a residential care facility, health care facility or correctional facility where you reside at the time your advance directive is completed.

我指定此人为我的医疗**代理**：
I appoint this person to be my health care **AGENT:**

代理姓名 AGENT NAME | 电子邮件 EMAIL

地址 ADDRESS

家庭电话 HOME PHONE | 工作电话 WORK PHONE | 手机 CELL PHONE

(如果您指定**共同代理**，请另页列出)
(If you appoint **CO-AGENTS**, list them on a separate sheet of paper)

如果该代理没空、不愿意或不能作为我的代理，我指定此人为我的**候补代理**：
If this agent is unavailable, unwilling or unable to act as my agent, I appoint this person as my **ALTERNATE AGENT:**

候补代理姓名 ALTERNATE AGENT NAME | 电子邮件 EMAIL

地址 ADDRESS

家庭电话 HOME PHONE | 工作电话 WORK PHONE | 手机 CELL PHONE

其他可以代表我就我的医疗决定进行咨询的人包括：
Others who may be consulted about medical decisions on my behalf include:

家庭医生（内科医生、医师助理或护师）
Primary care provider (Physician, PA or Nurse Practitioner):

姓名 NAME | 电话 PHONE

地址 ADDRESS

姓名 NAME | 电话 PHONE

地址 ADDRESS

不应咨询的人士包括：
Those who should NOT be consulted include:

（第一部分在下页继续）/ (PART ONE CONTINUED NEXT PAGE)

姓名 NAME | 出生日期 DOB | 日期 DATE

我希望我的预先指示在出现以下情况时开始执行：/ I want my Advance Directive to start:

- ☐ 我无法自己做出决定时
  When I cannot make my own decisions
- ◯ 现在
  Now
- ◯ 当这种情况发生时：
  When this happens:

第二部分：医疗目标和精神愿望
PART TWO: HEALTH CARE GOALS AND SPIRITUAL WISHES

我的整体医疗目标包括： / My overall health care goals include:

- ☐ 我想用任何医疗手段尽可能延长我的生命。
  I want to have my life sustained as long as possible by any medical means.
- ◯ 只有在我愿意的情况下，我才需要治疗来维持生命：
  I want treatment to sustain my life only if I will:
  - ☐ 能够与朋友和家人交流。
    be able to communicate with friends and family.
  - ☐ 能够照顾自己。
    be able to care for myself.
  - ☐ 在没有失能痛苦的情况下活着。
    live without incapacitating pain.
  - ☐ 有意识，知道周围的环境。
    be conscious and aware of my surroundings.
- ◯ 我只想要让我舒服的治疗。
  I only want treatment directed toward my comfort.

我想表达的其他目标、愿望或信念包括：
Additional Goals, Wishes, or Beliefs I wish to express include:

如果我得了危及生命的疾病时需要通知的人：
People to notify if I have a life-threatening illness:

如果我要死了，那么对我来说很重要的是(勾选选项)：/ If I am dying it is important for me to be (check choice):

- ☐ 在家
  At home
- ◯ 在医院
  In the hospital
- ◯ 其它：
  Other:
- ◯ 没有偏好
  No preference

我的精神关怀愿望包括： / My Spiritual Care Wishes include:

我的宗教/信仰：
My Religion/Faith:

宗教场所 PLACE OF WORSHIP | 电话 PHONE

地址 ADDRESS

以下物品、音乐或阅读会让我感到安慰：
The following items or music or readings would be a comfort to me:

姓名 NAME | 出生日期 DOB | 日期 DATE

第三部分：治疗的限制
PART THREE: LIMITATIONS OF TREATMENT

如果您已病重或临近死亡，您可以决定您想要或不想要什么样的治疗。无论治疗限制如何，您都有权控制您的疼痛和症状（恶心、疲劳、呼吸短促）。除非有明确的治疗限制，否则医疗团队奖竭尽所能挽救您的生命。

You can decide what kind of treatment you want or don't want if you become seriously ill or are dying. Regardless of the treatment limitations expressed, you have the right to have your pain and symptoms (nausea, fatigue, shortness of breath) managed. Unless treatment limitations are stated, the medical team is required and expected to do everything possible to save your life.

1.如果我的心脏停止跳动(选择一项): / **If my heart stops** (choose one):

☐ 我需要做CPR，试着让我的心脏恢复跳动。
I DO want CPR done to try to restart my heart.

◯ 我不想做CPR来让我的心脏恢复跳动。
I DON'T want CPR done to try to restart my heart.

CPR指的是心肺复苏，包括大力按压胸部、使用电刺激、药物支持或恢复心脏功能，以及人工呼吸(迫使空气进入肺部)。

CPR means cardio (heart)-pulmonary (lung) resuscitation, including vigorous compressions of the chest, use of electrical stimulation, medications to support or restore heart function, and rescue breaths (forcing air into your lungs).

2.如果我无法自己呼吸(选择一项): / **If I am unable to breathe on my own** (choose one):

☐ 我需要一台呼吸机，没有时间限制。
I DO want a breathing machine without any time limit.

◯ 我想在短时间内使用呼吸机，看看我能否活下来或好起来。
I want to have a breathing machine for a short time to see if I will survive or get better.

◯ 我不想要任何时间的呼吸机。
I DO NOT want a breathing machine for ANY length of time.

“呼吸机”指的是机械地将空气送入或排出肺部的设备，比如人工呼吸器。

“Breathing machine” refers to a device that mechanically moves air into and out of your lungs such as a ventilator.

3.如果我无法吞下足够的食物或水来维持生命(选择一项):
If I am unable to swallow enough food or water to stay alive (choose one):

☐ 我想要一个没有任何时间限制的喂食管。
I DO want a feeding tube without any time limits.

◯ 我想用短时间的喂食管来看看我能否活下来或好起来。
I want to have a feeding tube for a short time to see if I will survive or get better.

◯ 任何时候我都不想要喂食管。
I DO NOT want a feeding tube for any length of time.

注：如果您在另一个州接受治疗，您的代理可能不会自动有权不给或收回喂食管。如果您希望您的代理对关于喂食管做出决定，请勾选下面的框。

NOTE: If you are being treated in another state your agent may not automatically have the authority to withhold or withdraw a feeding tube. If you wish to have your agent decide about feeding tubes please check the box below.

☐ 我授权我的代理就喂食管做出决定。
I authorize my agent to make decisions about feeding tubes.

4.如果我病入膏肓，或病得很重，不太可能好转(选择一项):
If I am terminally ill or so ill that I am unlikely to get better (choose one):

☐ 我需要抗生素或其他药物来对抗感染。
I DO want antibiotics or other medication to fight infection.

◯ 我不需要抗生素或其他药物来对抗感染。
I DON'T want antibiotics or other medication to fight infection.

如果您已经声明在任何情况下都不需要心肺复苏、呼吸机、喂食管或抗生素，请与您的医生讨论，他可以填写一份DNR/COLST表格，以确保您不会接受您不想接受的治疗，特别是在紧急情况下。DNR/COLST令将在医院外执行。

If you have stated you DO NOT want CPR, a breathing machine, a feeding tube, or antibiotics under any circumstances, please discuss this with your doctor who can complete a DNR/COLST form to ensure you don't receive treatments you don't want, particularly in an emergency situation. A DNR/COLST order will be honored outside of the hospital setting.

治疗的其他限制我希望包括： / Additional Limitations of Treatment I wish to include:

姓名 NAME　　出生日期 DOB　　日期 DATE

第四部分：器官/组织捐赠及遗体埋葬/处置
PART FOUR: ORGAN/TISSUE DONATION & BURIAL/DISPOSITION OF REMAINS

我对器官和组织捐赠的意愿(勾选您的选择): / My wishes for organ & tissue donation (check your choices):

☐ 我同意捐赠以下器官和组织：
I consent to donate the following organs & tissues:

- ☐ 任何需要的器官
  Any needed organs
- ☐ 任何需要的组织(皮肤、骨骼、角膜)
  Any needed tissue (skin, bone, cornea)
- ☐ 我不愿捐赠下列器官及组织:
  I do not wish to donate the following organs and tissues:
- ☐ 我不想捐赠任何器官或组织
  I do not want to donate any organs or tissues
- ☐ 我想要我的医疗代理来决定
  I want my health care agent to decide

☐ 我希望将我的遗体捐赠给研究或教育项目。*(注：您必须事先与医学院或其他项目作出自己的安排。)*
I wish to donate my body to research or educational program(s). *(Note: you will have to make your own arrangements with a medical school or other program in advance.)*

我死后埋葬/处置遗体的指示(勾选并完成):
My Directions for Burial/Disposition of My Remains after I Die (check & complete):

☐ 我有一份葬礼安排的预需合同：
I have a Pre-Need Contract for Funeral Arrangements:

姓名 NAME　　电话 PHONE

地址 ADDRESS

我想让下列人员来决定我的葬礼或我的遗体的处置事项(勾选您的选择):
I want the following individuals to decide about my burial or disposition of my remains (check your choices):

☐ 代理 Agent　☐ 候补代理 Alternate Agent　☐ 家人： Family:

姓名 NAME　　电话 PHONE

地址 ADDRESS

☐ 其它：
Other:

姓名 NAME　　电话 PHONE

地址 ADDRESS

特定愿望(勾选您的选择): / Specific Wishes (check your choices):

☐ 我想要守灵/观影
I want a Wake/Viewing

☐ 我更喜欢土葬——如果可能的话，在以下地点:(墓地，地址，电话号码)
I prefer a Burial — If possible at the following location: (cemetery, address, phone number)

☐ 我更喜欢火葬——把我的骨灰保存或撒在下面:
I prefer Cremation — With my ashes kept or scattered as follows:

☐ 我想要一个追悼仪式，然后是土葬或火葬
I want a Funeral Ceremony with a burial or cremation to follow

☐ 我只希望有一个墓旁仪式
I prefer only a Graveside Ceremony

☐ 我只希望有一个土葬或火葬的纪念仪式
I prefer only a Memorial Ceremony with burial or cremation preceding

☐ 其他细节：(如音乐、朗诵、主礼)
Other Details: (such as music, readings, Officiant)

姓名
NAME

出生日期
DOB

日期
DATE

第五部分：签署的愿望声明
PART FIVE: SIGNED DECLARATION OF WISHES

您必须在两位成年证人面前签字。下列人员**不**得作为证人签字：
您的代理、配偶、父母、兄弟姐妹、子女或孙辈。

You must sign this before TWO adult witnesses. The following people may **not** sign as witnesses: your agent(s), spouse, parents, siblings, children or grandchildren.

我声明，这份文件反映了我的医疗愿望，我是自愿签署这份预先指示的。

I declare that this document reflects my health care wishes and that I am signing this Advance Directive of my own free will.

签名
SIGNED .....

日期
DATE

我确认，签署人理解预先指示的性质，并在签署时不受胁迫或不当影响。(请签字并打印)

I affirm that the signer appeared to understand the nature of this advance directive and to be free from duress or undue influence at the time this was signed. *(Please sign and print)*

证人1（打印姓名）
WITNESS 1 (PRINT NAME)

签名
SIGNATURE .....

日期
DATE

证人2（打印姓名）
WITNESS 2 (PRINT NAME)

签名
SIGNATURE .....

日期
DATE

如果签署本文件者已入院或目前是**医院**病人，下列人员之一必须签字并确认，他们已经解释了预先指示的性质和效果，而且在签字时，病人表现出理解文件内容且没有受到胁迫或不当影响：*指定医院解释人员、监察员、心理健康病人代表、认可的神职人员、佛蒙特州律师或遗嘱检验法院指定人员。*

If the person signing this document is being admitted to or is a current patient in a **hospital**, one of the following must sign and affirm that they have explained the nature and effect of the advance directive and the patient appeared to understand and be free from duress or undue influence at the time of signing: *designated hospital explainer, ombudsman, mental health patient representative, recognized member of the clergy, Vermont attorney, or Probate Court designee.*

如果签署本文件者已入住或目前是**疗养院或养老院**的住客，下列人员之一必须签字并确认，他们已经解释了预先指示的性质和效果，而且在签字时，住客表现出理解文件内容且没有受到胁迫或不当影响：*监察员、认可的神职人员、佛蒙特州律师、遗嘱检验法院指定人员、指定医院解释人员、心理健康病人代表、非该院雇用的临床医生或经过适当培训的疗养院/养老院志愿者。*

If the person signing this document is being admitted to or is a resident in a **nursing home or residential care facility**, one of the following must sign and affirm that they have explained the nature and effect of the advance directive and the resident appeared to understand and be free from duress or undue influence at the time of signing: *an ombudsman, recognized member of the clergy, Vermont attorney, Probate Court designee, designated hospital explainer, mental health patient representative, clinician not employed by the facility, or appropriately trained nursing home/ residential care facility volunteer.*

上文所述的解释者也可以作为两个必需的证人之一。

The explainer as outlined above may also serve as one of the two required witnesses.

姓名
NAME

头衔/职位
TITLE/POSITION

电话
PHONE

地址
ADDRESS

签名
SIGNATURE .....

日期
DATE

姓名
NAME

出生日期
DOB

日期
DATE

以下是我的预先指示的副本 (请勾选):
The following have a copy of my Advance Directive (please check):

☐ 佛蒙特州预先指示登记处
Vermont Advance Directive Registry

注册日期:
Date registered:

☐ 医疗代理
Health care agent

☐ 候补医疗代理
Alternate health care agent

☐ 医生/提供者:
Doctor/Provider(s):

☐ 医院:
Hospital(s):

☐ 家庭成员:请列出:
Family Member(s): Please list:

姓名
NAME
地址
ADDRESS

姓名
NAME
地址
ADDRESS

姓名
NAME
地址
ADDRESS

姓名
NAME
地址
ADDRESS

姓名
NAME
地址
ADDRESS

☐ 其它:
Other:

姓名
NAME
地址
ADDRESS

姓名
NAME
地址
ADDRESS

姓名
NAME
地址
ADDRESS

姓名
NAME
地址
ADDRESS

姓名
NAME
地址
ADDRESS

姓名
NAME
地址
ADDRESS

VERMONT
DEPARTMENT OF HEALTH

Registry Use Only
Received: _____
Confirmed: _____

佛蒙特州预先指示登记处
登记协议及更改表格授权书
(根据佛蒙特州预先指示规则提供的文件A和B)

Vermont Advance Directive Registry
Registration Agreement & Authorization to Change Form
(Documents A & B per the Vermont Advance Directive Rule)

说明/ Directions

1. 阅读第3页的登记政策，并完成以下相关部分。请打印清楚。
   Read the Registration Policy on page 3 and complete the relevant sections below. Please type or print clearly.
   a. **首次登记者：**完成必要的登记信息和文件A。
      First-time Registrants: Complete the Required Registrant Information & Document A.
   b. **更新已存档的预先指示：**完成必要的登记信息和文件B。
      Updating an Advance Directive already on file: Complete the Required Registrant Information & Document B.
2. 附上一份您的预先指示的签字和见证人的副本。
   Attach a signed and witnessed copy of your advance directive.
3. 登记必须包括一份完整并签署的登记协议或更改授权表格，以及一份签署并见证的预先指示文件副本。
   Registrations **must** include a completed and signed Registration Agreement or Authorization to Change form and a copy of the signed and witnessed advance directive document.
4. 表格一旦完成并签名，请通过电子邮件、邮件或传真发送表格：
   Once forms are completed and signed, send forms by email, mail **or** fax:

电子邮件至： E-mail to: VADRSubmissions@uslwr.com

或邮件至： Or Mail to: Vermont Advance Directive Registry (VADR)
PO Box 2789
Westfield, NJ 07091-2789

或传真至： Or Fax to: 908-654-1919

更多信息请访问：http://healthvermont.gov/vadr/ 或致电1-888-548-9455
For additional information visit: http://healthvermont.gov/vadr/ or call 1-888-548-9455

必要的登记者信息 / Required Registrant Information

姓名： Name: 名字 First _____ 中间名 Middle _____ 姓氏 Last _____ 词尾 Suffix ____

出生日期： Date of Birth: __ __/__ __/__ __ __ __

主要邮寄地址： Primary Mailing Address: _____

镇/市： Town/City: _____ **州：** State: _____ **邮编：** Zip code: _____

电话号码： Phone Number: 主要 Primary (__ __ __) __ __ __-__ __ __ __ 其它：Other: (__ __ __) __ __ __-__ __ __ __

您愿意通过电子邮件联系您吗？ Would you like to be contacted by e-mail? ☐ 否 No ☐ 是 Yes

电邮地址： Email Address: _____

第二邮寄地址(如适用)： Secondary Mailing Address (if applicable): _____

镇/市： Town/City: _____ **州：** State: _____ **邮编：** Zip code: _____

紧急联系人 / Emergency Contacts

主要： Primary: 姓名：Name: _____

与登记者的关系：Relationship to Registrant: _____ 电话号码：Phone Number: (__ __ __) __ __ __-__ __ __ __

第二联系人： Secondary: 姓名：Name: _____

与登记者的关系：Relationship to Registrant: _____ 电话号码：Phone Number: (__ __ __) __ __ __-__ __ __ __

VERMONT
DEPARTMENT OF HEALTH

Registry Use Only
Received: _____
Confirmed: _____

注意：所有提交给登记处的文件必须包括登记者的预先指示的签字和见证的副本。这适用于首次提交的文件和对现有文件的更新。

NOTICE: All submissions to the Registry must include a signed and witnessed copy of the registrant's Advance Directive. This applies to both first-time submissions and updates to existing documents.

文件A:登记协议
Document A: Registration Agreement

仅当这是您第一次登记您的预先指令时，请完成此部分。

Complete this section **only** if this is your first time registering your advance directive.

本人 _____ **(打印姓名)**请求在佛蒙特州预先指示登记处登记我的预先指示，并在佛蒙特州法律允许下授权其访问。本人同意并确认：所提供的信息准确无误；本人已阅读、理解并同意登记处的登记政策条款；本人将妥善保管本人的登记身份证号及钱包卡，防止他人非法访问；若本人登记资料或预先指示有任何更改，本人将立即以书面通知登记处。本人自愿签署本协议，不受任何一方的胁迫、威胁或不当影响。我理解任何可以访问我的钱包卡的人都可以用它来获取我的文件和个人信息。此授权在我撤销之前一直有效。

I, _____ (**print name**) request that my advance directive be registered in the Vermont Advance Directive Registry, and authorize its access as allowed by Vermont law. By signing below, I acknowledge and affirm that: the information provided is accurate; I have read, understand, and agree to the terms of the Registry Registration Policy; I will safeguard my registrant identification number and wallet card from unauthorized access; and I will immediately notify the Registry in writing of changes to my registration information or advance directive. I execute this agreement voluntarily and without coercion, duress, or undue influence by any party. I understand that anyone who has access to my wallet card can use it to gain access to my documents and personal information. This authorization remains in effect until I revoke it.

登记者签名：
Signature of Registrant: _____

日期：
Date: _____

文件B：更改授权
Document B: Authorization to Change

仅当您目前已登记并对登记处已登记的预先指示作出更改时才完成。

Complete **only** if you are currently registered and making updates to an advance directive already on file with the registry.

勾选下面适用于您的提交的框。

Check the box below that applies to your submission.

☐ **修改：**勾选此框可修改现有的预先指示。以前的文件记录将保留在您的档案中。
Amend: Check this box to amend your existing advance directive. Prior document history will be retained in your file.

☐ **替换：**勾选此框可替换现有的预先指示。以前的文件记录将不会保留在您的档案中。
Replace: Check this box to replace your existing advance directive. Prior document history will not be retained in your file.

☐ **暂停：**勾选此框可在确定的一段时间内暂时停用全部或部分预先指示。
Suspend: Check this box to temporarily inactivate all or part of your advance directive for a defined period of time.

开始日期：
Begin Date: _____

结束日期
End Date: _____

☐ **撤销：**勾选此框可从登记处删除预先指示。(这将永久从登记处删除)
Revoke: Check this box to delete your advance directive from the registry. (This is a permanent removal from the Registry)

本人 _____ **(打印姓名)**证明此表格准确地代表我所作的更改，而这些更改是准确的。此外，我授权这些更改将反映在预先指示登记处。

I, _____ (print name) certify that this form accurately represents the changes I have made, and these changes are accurate. Additionally, I authorize the changes to be reflected in the Advance Directive Registry.

登记者签名：
Signature of Registrant: _____

日期：
Date: _____

VERMONT
DEPARTMENT OF HEALTH

登记政策 / Registration Policy

预先指示是一种法律文件，它传达一个人在丧失行为能力或因其他原因无法作出决定时，关于其医疗治疗和结束生命选择的愿望。佛蒙特州预先指示登记处是一个数据库，允许人们以电子方式将其预先指示文件副本存储在一个安全的数据库中。经授权的医疗提供者、医疗设施、养老院、丧葬承办人和火葬场经营者可在需要时访问该数据库。欲了解更多信息，请访问：http://healthvermont.gov/vadr/.

An advance directive is a legal document that conveys a person's wishes regarding their health care treatment and end of life choices should they become incapacitated or otherwise unable to make those decisions. The Vermont Advance Directive Registry is a database that allows people to electronically store a copy of their advance directive document in a secure database. That database may be accessed when needed by authorized health care providers, health care facilities, residential care facilities, funeral directors, and crematory operators. For more information, visit: http://healthvermont.gov/vadr/.

1. 要登记预先指示，登记者必须填写并将登记协议表格连同预先指示文件副本发送到:

   To register an advance directive, the registrant must complete and send the Registration Agreement form along with a copy of the advance directive document to:

   The Vermont Advance Directive Registry
   PO Box 2789
   Westfield, New Jersey 07091-2789

2. 在收到登记协议及其附件后，登记处将扫描预先指示，并将其与登记协议中的登记者识别信息一起存储在数据库中。登记处将向登记者发送一封确认函，同时附上一个登记号、使用登记号访问登记处网站文件的说明、钱包卡和贴在驾照或保险卡上的贴纸。登记者在收到确认信及登记资料后，登记即告有效。

   Upon receipt of the Registration Agreement and attachments, the Registry will scan the advance directive and store it in the database along with registrant identifying information from the Registration Agreement. The Registry will send a confirmation letter to the registrant along with a registration number, instructions for using the registration number to access documents at the Registry website, a wallet card, and stickers to affix to a driver's license or insurance card. The registration is not effective until receipt of the confirmation letter and registration materials is made by registrant.

3. 登记者应该将钱包卡上的登记号分享给任何有权访问其预先指示的人：如，登记者的代理、家庭成员或医生。任何人都可以使用登记号码访问某人的预先指示。此外，在没有登记号码的情况下，经授权的医疗提供者可以使用登记者的个人身份信息在登记处搜索特定个人的预先指示。

   Registrants should share the registration number from the wallet card with anyone that should have access to their advance directives: for example, the registrant's agent, family members, or physician. Anyone may access a person's advance directive using the registration number. Additionally, when the registration number is not readily available, an authorized health care provider can search the Registry for a specific person's advance directive using a registrant's personal identifying information.

4. 登记者有责任确保：

   The registrant is responsible for ensuring that:

   a. 根据佛蒙特州的法律，预先指示将被妥善执行。

      The advance directive is properly executed in accordance with the laws of the state of Vermont.

   b. 如果预先指示正本的影印本是正确和可读的，则发送给登记处的副本也是正确和可读的。

      The copy of the advance directive sent to the Registry, if a photocopy of the original, is correct and readable.

   c. 登记协议和预先指示文件中的信息都是准确和最新的。

      The information in both the Registration Agreement and advance directive documents is accurate and up to date.

   d. 如预先指示或登记资料有任何更改，请填妥并提交一份附有更改的“更改授权书”表格，或最好附上预先指示的更新副本，以尽快通知登记处。

      The Registry is notified as soon as possible of any changes to the advance directive or registration information by completing and submitting an Authorization to Change form with the changes appended, or preferably, with an updated copy of the advance directive to the Registry.

5. 首次登记以及随后对登记信息或预先指示文件的更改和更新是免费的。

   Initial registration as well as subsequent changes and updates to the registration information or the advance directive documents are free of charge.

6. 登记协议应继续有效，直至登记处收到登记者死亡的可靠信息，或登记者书面要求终止登记协议。本协议终止时，登记处将从登记处数据库中删除登记者的预先指示，提供者将无法访问该文件。

   The Registration Agreement shall remain in effect until the Registry receives reliable information that the registrant is deceased, or the registrant requests in writing that the Registration Agreement be terminated. When the Agreement is terminated, the Registry will remove registrant's advance directive from the Registry database, and the file will no longer be accessible to providers.

7. 只有登记处可以更改登记协议的条款。

   Only the Registry can change the terms of the Registration Agreement.