Mwelekezo wa mapema kuhusu Utunzaji wa Afya wa Vermont

Imetayarishwa na Mfumo wa Maadili wa Vermont

Vermont Advance Directive for Health Care

Prepared by the Vermont Ethics Network

SWAHILI

MAELEZO NA MAAGIZO
EXPLANATION & INSTRUCTIONS

- Una haki ya: / You have the right to:
  1. Kutaja mtu mwingine ili akufanyie maamuzi ya utunzaji wa afya wakati au ikiwa huwezi kuyafanya wewe mwenyewe.
     Name someone else to make health care decisions for you when or if you are unable to make them yourself.
  2. Kutoa maagizo kuhusu aina ya huduma za afya unazotaka au usizotaka.
     Give instructions about what types of health care you want or do not want.
- Ni muhimu kuzungumza na watu wako wa karibu zaidi na wahudumu wako wa afya kuhusu malengo, matakwa na mapendekezo yako ya matibabu.
  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.
- Unaweza kutumia fomu hii yote au unaweza kutumia sehemu yake yoyote. Kwa mfano, ikiwa ungependa tu kuchagua wakala katika Sehemu ya Kwanza, unaweza kujaza sehemu hiyo tu kisha uende kwenye Sehemu ya Tano ili utie saini mbele ya mashahidi wanaofaa.
  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.
- Unaweza kutumia fomu nyingine mradi tu iwe imeshuhudiwa ipasavyo. Fomu nyingine zenye maelezo ya kina kuhusu chaguo bora na taarifa inayohusu mapendeleo ya utunzaji wa afya ya akili zinaweza kupatikana kwenye tovuti ya VEN katika www.vtethicsnetwork.org.
  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.

Sehemu ya KWANZA ya fomu hii inakuruhusu umtaje mtu kama "**wakala**" wako ili akufanyie maamuzi ya afya ikiwa hutaweza au hutaki kufanya maamuzi wewe mwenyewe. Unaweza pia kutaja mawakala wengine. Unapaswa kumchagua mtu unayemwamini, ambaye atakuwa huru kukufanyia maamuzi ambayo yanaweza kuwa magumu kwako. Anapaswa kuzingatia maadili yako anapokufanyia maamuzi **na kukubali** kutenda kama wakala wako. Unaweza kujaza fomu ya Mwelekezo wa Mapema kuhusu matibabu ukieleza mapendeleo yako ya matibabu *hata kama huna wakala*. Wahudumu wa matibabu watafuata maagizo yako yaliyo katika Mwelekezo wa Mapema kuhusu matibabu bila wakala kadri wawezavyo, lakini kuwa na mtu aliyeteuliwa rasmi kuwa wakala wako ili akufanyie maamuzi kutasaidia wahudumu wa afya na watu wanaokujali wafanye maamuzi bora zaidi katika hali ambazo huenda hazikufafanuliwa katika Mwelekezo wako wa Mapema kuhusu matibabu Kulingana na sheria ya Vermont, jamaa wa karibu hatakufanyia maamuzi kiotomatiki ikiwa huwezi kufanya maamuzi. Ndiyo maana ni bora kumchagua mtu mapema.

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.

Sehemu ya PILI ya fomu hii inakuruhusu utaje **Malengo na Matakwa ya Matibabu**. Chaguo zimetolewa ili ueleze matakwa yako kuhusu kuwa na, kutokuwa na, au kuacha matibabu katika hali fulani. Nafasi pia imetolewa ili uandike matakwa yoyote ya ziada au mahususi kulingana na maadili, hali ya afya au imani yako.

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.

Sehemu ya TATU ya fomu hii inakuruhusu ueleze matakwa yako kuhusu **Matibabu ambayo huenda usipate**. Matibabu haya ni pamoja na CPR, mashine za kupumulia, mabomba ya kulisha, na viuavijasumu. Una nafasi ya kuandika matakwa yoyote ya ziada. JUA KWAMBA: Ikiwa HUTAKI CPR, mashine ya kupumulia, bomba la kulisha, au viuavijasumu, tafadhali jadiliana na daktari wako, anayeweza kutoa **agizo la DNR/COLST** (Usifufue/Agizo la Daktari la Matibabu ya Kuendeleza Maisha) ili uhakikishe kuwa hutapokea matibabu usiyotaka, hasa wakati wa dharura. Wafanyakazi wa Matibabu ya Dharura wanatakiwa wakupe matibabu ya kuokoa maisha isipokuwa kama wana agizo la DNR/COLST lililotiwa saini linalobainisha matibabu fulani ambayo huenda usipewe. Ikiwa hakuna agizo la DNR/COLST timu ya matibabu ya dharura itafanya CPR kwa kuwa haitakuwa na wakati wa kuangalia Mwelekezo wa Mapema kuhusu matibabu, familia, wakala au daktari wako.

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.

Sehemu ya NNE ya fomu hii inakuruhusu ueleze matakwa yako kuhusu **kutolewa viungo/tishu na mapendeleo ya mazishi, kuzikwa na kutupwa** kwa mabaki yako.

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.

Sehemu ya TANO ni ya saini. Lazima utie saini na uandike tarehe kwenye fomu mbele ya mashahidi wawili ambao ni watu wazima. Watu wafuatao hawawezi kuwa mashahidi: wakala wako na mawakala wengine; mke/mume wako au mpenzi wako; wazazi; ndugu; watoto au wajukuu.

Unapaswa kumpa wakala wako, na wakala(mawakala) wengine, daktari wako, familia yako na kituo chochote cha huduma ya afya unapoishi au ambako huenda ukapata huduma nakala za fomu iliyojazwa. Tafadhali kumbuka mtu aliye na nakala ya Mwelekezo wako wa Mapema kuhusu matibabu ili isasishwe mapendeleo yako yakibadilika.

Pia unahimizwa utume nakala ya Mwelekezo wako wa Mapema kuhusu matibabu kwa Usajili wa Mwelekezo wa Mapema kuhusu matibabu wa Vermont pamoja na Fomu ya Makubaliano ya Usajili inayopatikana mwishoni mwa hati hii.

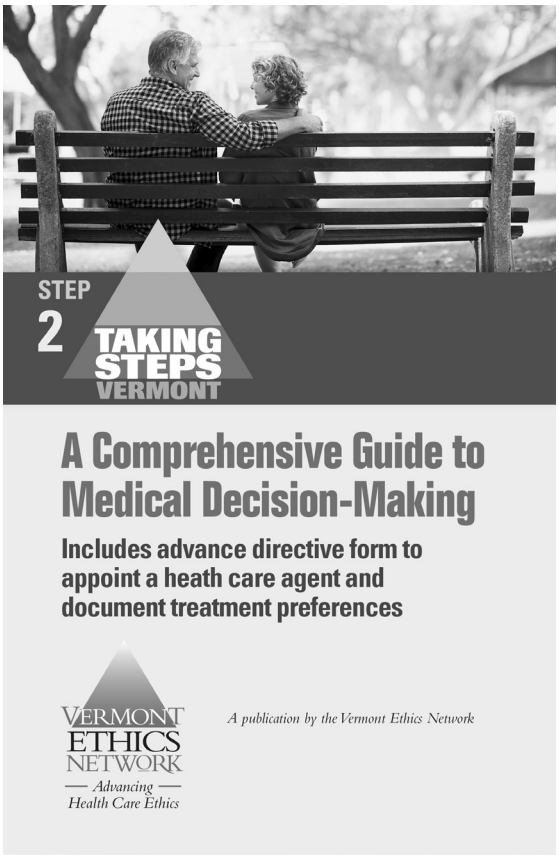
Una haki ya kubatilisha sehemu zote au fulani za Mwelekezo huu wa Mapema kuhusu matibabu kwa ajili ya matibabu au kubadilisha fomu hii wakati wowote. Usipoibatilisha, nakala zote za zamani zinapaswa kuharibiwa. Ukifanya mabadiliko na umetuma nakala ya hati yako asili kwa Usajili wa Mwelekezo wa Mapema kuhusu matibabu wa Vermont, hakikisha umewatumia nakala mpya au fomu ya taarifa ya mabadiliko yenye maelezo yanayohitajika ili kusasisha Mwelekezo wako wa Mapema kuhusu matibabu.

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.



Unaweza kutaka kusoma kijitabu cha *Taking Steps (Kuchukua Hatua)* ili ufikirie na ujadili chaguzi na hali tofauti na wakala(mawakala) wako au wapendwa wako.

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.

Nakala za *Taking Steps* zinaweza kununuliwa katika:

Copies of *Taking Steps* can be purchased from:

Vermont Ethics Network
61 Elm Street
Montpelier, VT 05602.
Simu (Tel) **(802) 828-2909**
Faksi (Fax) **(802) 828-2646**

www.vtethicsnetwork.org

Kwa taarifa kuhusu Usajili wa Mwelekezo wa Mapema kuhusu matibabu wa Vermont tembelea:

For information about the Vermont Advance Directive Registry visit:

Tovuti ya VEN: www.vtethicsnetwork.org
VEN website

au / or

Tovuti ya Usajili katika Idara ya Afya ya Vermont: www.healthvermont.gov/vadr
Registry website at the Vermont Department of Health: www.healthvermont.gov/vadr

Mwelekezo wa mapema kuhusu Utunzaji wa Afya wa Vermont

Vermont Advance Directive for Health Care

JINA LAKO YOUR NAME | **TAREHE YA KUZALIWA** DATE OF BIRTH | **TAREHE** DATE

ANWANI ADDRESS

JIJI CITY | **JIMBO** STATE | **POSTA** ZIP

SEHEMU YA KWANZA: WAKALA WAKO WA HUDUMA YA UTUNZAJI
PART ONE: YOUR HEALTH CARE AGENT

Wakala wako wa huduma ya utunzaji anaweza kufanya maamuzi ya utunzaji wa afya kwa niaba yako ikiwa huwezi au hutaki kufanya maamuzi wewe mwenyewe. Unapaswa kumchagua mtu unayemwamini, anayeelewa matakwa yako na anayekubali kutenda kama wakala wako. Daktari wako **HAWEZI** kuwa wakala wako isipokuwa kama ni jamaa. Wakala wako **HAWEZI** kuwa mmiliki, mwendesha shughuli, mfanyakazi au mkandarasi wa kituo cha huduma ya utunzaji, kituo cha huduma za afya au kituo cha kurekebisha tabia unapoishi wakati wa kukamilisha mwelekezo wako wa mapema kuhusu matibabu.

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.

Ninamteua mtu huyu awe **WAKALA** wangu wa huduma ya afya:
I appoint this person to be my health care **AGENT:**

JINA LA WAKALA AGENT NAME | **BARUA PEPE** EMAIL

ANWANI ADDRESS

SIMU YA NYUMBANI HOME PHONE | **SIMU YA KAZINI** WORK PHONE | **SIMU YA MKONONI** CELL PHONE

(Ukiwateua **WAKALA WASHIRIKA**, waandike kwenye karatasi tofauti)
(If you appoint **CO-AGENTS**, list them on a separate sheet of paper)

Ikiwa wakala huyu **hapatikani**, hataki au hawezi kutenda kama wakala wangu, ninamteua mtu huyu awe **WAKALA wangu MWINGINE:**
If this agent is unavailable, unwilling or unable to act as my agent, I appoint this person as my **ALTERNATE AGENT:**

WAKALA MWINGINE ALTERNATE AGENT NAME | **BARUA PEPE** EMAIL

ANWANI ADDRESS

SIMU YA NYUMBANI HOME PHONE | **SIMU YA KAZINI** WORK PHONE | **SIMU YA MKONONI** CELL PHONE

Watu wengine wanaoweza kutoa maoni kuhusu maamuzi ya matibabu kwa niaba yangu ni pamoja na:
Others who may be consulted about medical decisions on my behalf include:

Mtoa huduma wa msingi (Daktari, Msaidizi wa Daktari au Muuguzi):
Primary care provider (Physician, PA or Nurse Practitioner):

JINA NAME | **SIMU** PHONE

ANWANI ADDRESS

JINA NAME | **SIMU** PHONE

ANWANI ADDRESS

Watu WASIOPASWA kutoa maoni ni pamoja na:
Those who should NOT be consulted include:

JINA NAME | **TAREHE YA KUZALIWA** DOB | **TAREHE** DATE

Ninataka Mwelekezo wangu wa Mapema kuhusu matibabu uanze: / I want my Advance Directive to start:

- ☐ Wakati siwezi kufanya maamuzi mimi mwenyewe
  When I cannot make my own decisions
- ◯ Sasa
  Now
- ◯ Jambo hili likitokea:
  When this happens:

SEHEMU YA PILI: MALENGO YA HUDUMA YA AFYA NA MATAKWA YA KIROHO
PART TWO: HEALTH CARE GOALS AND SPIRITUAL WISHES

Malengo yangu ya jumla ya afya ni pamoja na: / My overall health care goals include:

- ☐ Ninataka kuendeleza maisha yangu kwa muda mrefu iwezekanavyo kwa njia yoyote ya kimatibabu.
  I want to have my life sustained as long as possible by any medical means.
- ◯ Ninataka matibabu ya kuendeleza maisha yangu ikiwa tu:
  I want treatment to sustain my life only if I will:
  - ☐ nitaweza kuwasiliana na marafiki na familia.
    be able to communicate with friends and family.
  - ☐ nitaweza kujitunza mimi mwenyewe.
    be able to care for myself.
  - ☐ nitaishi bila maumivu makali.
    live without incapacitating pain.
  - ☐ nitakuwa na ufahamu na nitajua mazingira yangu.
    be conscious and aware of my surroundings.
- ◯ Ninataka tu matibabu ya kunifariji.
  I only want treatment directed toward my comfort.

Malengo ya Ziada, Matakwa, au Imani ninazotaka kueleza ni pamoja na:
Additional Goals, Wishes, or Beliefs I wish to express include:

Watu wa kuwajulisha ikiwa nina ugonjwa unaotishia maisha:
People to notify if I have a life-threatening illness:

Ikiwa ninakufa ni muhimu kwangu kwamba niwe (tia alama kwenye moja): / If I am dying it is important for me to be (check choice):

- ☐ Nyumbani
  At home
- ◯ Hospitalini
  In the hospital
- ◯ Nyingine:
  Other:
- ◯ Sina mapendeleo
  No preference

Matakwa yangu ya Utunzaji wa Kiroho ni pamoja na: / My Spiritual Care Wishes include:

Dini/Imani Yangu:
My Religion/Faith:

MAHALI PA IBADA
PLACE OF WORSHIP

SIMU
PHONE

ANWANI
ADDRESS

Vitu au muziki au vitabu vifuatavyo vitanifariji:
The following items or music or readings would be a comfort to me:

JINA NAME | **TAREHE YA KUZALIWA** DOB | **TAREHE** DATE

SEHEMU YA TATU: MATIBABU AMBAYO HUENDA NISIPATE
PART THREE: LIMITATIONS OF TREATMENT

Unaweza kuamua aina ya matibabu unayotaka au ambayo hutaki ikiwa unaugua sana au unakufa. Bila kujali matibabu ambayo umesema huenda usipate, una haki kuhakikishiwa kwamba maumivu na dalili zako (kichefuchefu, uchovu, kushindwa kupumua) zinadhibitiwa. Isipokuwa kama umetaja matibabu ambayo huenda usipate, timu ya kimatibabu inahitajika na inatarajiwa kufanya kila kitu kinachowezekana kuokoa maisha yako.

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. Moyo wangu ukikoma kupiga (chagua moja):
If my heart stops (choose one):

☐ NATAKA CPR ili moyo wangu ujaribu kupiga tena.
I DO want CPR done to try to restart my heart.

◯ SITAKI CPR ili moyo wangu ujaribu kupiga tena.
I DON'T want CPR done to try to restart my heart.

CPR inamaanisha ufufuaji wa moyo (wa mapafu), ikiwa ni pamoja na ukandamizaji wa kifua, kutumia kichocheo cha umeme, dawa za kusaidia au kurejesha utendaji wa moyo, na pumzi za kuokoa (kulazimisha hewa kwenye mapafu yako).
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).

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2. Ikiwa siwezi kupumua peke yangu (chagua moja):
If I am unable to breathe on my own (choose one):

☐ NATAKA mashine ya kupumulia bila kikomo cha wakati.
I DO want a breathing machine without any time limit.

◯ Ninataka mashine ya kupumulia kwa muda mfupi ili kuona ikiwa nitaishi au nitapata nafuu.
I want to have a breathing machine for a short time to see if I will survive or get better.

◯ SITAKI mashine ya kupumulia kwa muda wowote.
I DO NOT want a breathing machine for ANY length of time.

"Mashine ya kupumulia" ni kifaa kinachoingiza hewa ndani na nje ya mapafu yako kama vile kipitisha hewa.
"Breathing machine" refers to a device that mechanically moves air into and out of your lungs such as a ventilator.

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3. Ikiwa siwezi kumeza chakula au maji ya kutosha ili niwe hai (chagua moja):
If I am unable to swallow enough food or water to stay alive (choose one):

☐ NATAKA bomba la kulisha bila kikomo cha wakati.
I DO want a feeding tube without any time limits.

◯ Ninataka bomba la kulisha kwa muda mfupi ili kuona ikiwa nitaishi au nipata nafuu.
I want to have a feeding tube for a short time to see if I will survive or get better.

◯ SITAKI bomba la kulisha kwa muda wowote.
I DO NOT want a feeding tube for any length of time.

JUA KWAMBA: Iwapo unatibiwa katika jimbo lingine huenda wakala wako asiwe na mamlaka ya kiotomatiki ya kuzuia au kuondoa bomba la kulisha. Ikiwa ungependa wakala wako aamue kuhusu mabomba ya kulisha tafadhali tia alama kwenye kisanduku kilicho hapa chini. / *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.*

☐ Ninamruhusu wakala wangu afanye maamuzi kuhusu mabomba ya kulisha.
I authorize my agent to make decisions about feeding tubes.

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4. Ikiwa nina ugonjwa usiotibika au hakuna uwezekano wa kupata nafuu (chagua moja):
If I am terminally ill or so ill that I am unlikely to get better (choose one):

☐ NATAKA viuavijasumu au dawa nyingine za kupambana na maambukizi.
I DO want antibiotics or other medication to fight infection.

◯ SITAKI viuavijasumu au dawa nyingine za kupambana na maambukizi.
I DON'T want antibiotics or other medication to fight infection.

Ikiwa umesema kwamba HAUTAKI CPR, mashine ya kupumulia, bomba la kulisha, au viuavijasumu katika hali yoyote ile, tafadhali jadiliana na daktari wako, anayeweza kujaza fomu ya DNR/COLST ili uhakikishe kuwa hutapokea matibabu usiyotaka, hasa wakati wa dharura. Agizo la DNR/COLST litatekelezwa nje ya hospitali.

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.

Matibabu Mengine ya Ziada ambayo Huenda Nisipate: / Additional Limitations of Treatment I wish to include:

JINA NAME | **TAREHE YA KUZALIWA** DOB | **TAREHE** DATE

SEHEMU YA NNE: KUTOLEWA VIUNGO/TISHU NA MAZISHI/KUTUPWA KWA MABAKI
PART FOUR: ORGAN/TISSUE DONATION & BURIAL/DISPOSITION OF REMAINS

Matakwa yangu ya kutolewa viungo na tishu (tia alama kwenye chaguo zako):
My wishes for organ & tissue donation (check your choices):

☐ Ninakubali kutoa viungo na tishu zifuatazo:
I consent to donate the following organs & tissues:

- ☐ Viungo vyovyote vinavyohitajika
  Any needed organs
- ☐ Tishu yoyote inayohitajika (ngozi, mfupa, konea)
  Any needed tissue (skin, bone, cornea)
- ☐ Sitaki kutoa viungo na tishu zifuatazo:
  I do not wish to donate the following organs and tissues:
- ☐ Sitaki kutoa viungo au tishu zozote
  I do not want to donate any organs or tissues
- ☐ Nataka wakala wangu wa afya aamue
  I want my health care agent to decide

☐ Ningependa kutoa mwili wangu kwa ajili ya utafiti au mpango(mipango) ya kielimu. *(Jua kwamba: itabidi ufanye mipango yako mwenyewe na shule ya kimatibabu au mpango mwingine mapema.)* / 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.)*

Maagizo Yangu ya Kuzikwa/Kutupwa kwa Mabaki Yangu baada ya Kufa (tia alama na ukamilishe):
My Directions for Burial/Disposition of My Remains after I Die (check & complete):

☐ Nina Mkataba wa Maelekezo kuhusu Mipango ya Mazishi:
I have a Pre-Need Contract for Funeral Arrangements:

JINA NAME | **SIMU** PHONE

ANWANI ADDRESS

Ninataka watu wafuatao waamue kuhusu mazishi yangu au kutupwa kwa mabaki yangu (tia alama kwenye chaguo zako):
I want the following individuals to decide about my burial or disposition of my remains (check your choices):

☐ Wakala / Agent ☐ Wakala Mwingine / Alternate Agent ☐ Familia: / Family:

JINA NAME | **SIMU** PHONE

ANWANI ADDRESS

☐ Mwingine: / Other:

JINA NAME | **SIMU** PHONE

ANWANI ADDRESS

Matakwa Maalum (tia alama kwenye chaguo zako): / Specific Wishes (check your choices):

☐ Nataka Kesha/Kutazamwa
I want a Wake/Viewing

☐ Napendelea Mazishi — Ikiwezekana katika eneo lifuatalo: (makaburini, anwani, nambari ya simu)
I prefer a Burial — If possible at the following location: (cemetery, address, phone number)

☐ Napendelea Uchomaji maiti — Na majivu yangu yahifadhiwe au yatupwe ifuatavyo:
I prefer Cremation — With my ashes kept or scattered as follows:

☐ Nataka Sherehe ya Mazishi alafu nizikwe au maiti yangu ichomwe
I want a Funeral Ceremony with a burial or cremation to follow

☐ Napendelea Sherehe ya Kaburini tu
I prefer only a Graveside Ceremony

☐ Ninapendelea tu Sherehe ya Ukumbusho na mazishi au uchomaji maiti
I prefer only a Memorial Ceremony with burial or cremation preceding

☐ Maelezo Mengine: (kama vile muziki, vitabu, Afisa)
Other Details: (such as music, readings, Officiant)

JINA
NAME

TAREHE YA KUZALIWA
DOB

TAREHE
DATE

SEHEMU YA TANO: AZIMIO LA MATAKWA LILILOTIWA SAINI
PART FIVE: SIGNED DECLARATION OF WISHES

Lazima utie saini mbele ya mashahidi WAWILI ambao ni watu wazima. Watu wafuatao **hawawezi** kutia saini kama mashahidi: Wakala(mawakala) wako, mke/mume, wazazi, ndugu, watoto au wajukuu.

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.

Ninatangaza kwamba hati hii inaonyesha matakwa yangu ya huduma za afya na kwamba ninatia saini kwenye Mwelekezo huu wa Mapema kuhusu matibabu kwa hiari.

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

IMETIWA SAINI
SIGNED .....

TAREHE
DATE

Ninathibitisha kwamba aliyetia saini alionekana kuwa anaelewa maana ya mwelekezo huu wa mapema kuhusu matibabu na hakushurutishwa au kushawishiwa wakati wa kutia saini. *(Tafadhali tia saini na uchapishe)*

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)*

SHAHIDI WA 1 (JINA LILILOCHAPISHWA)
WITNESS 1 (PRINT NAME)

SAINI
SIGNATURE .....

TAREHE
DATE

SHAHIDI WA 2 (JINA LILILOCHAPISHWA)
WITNESS 2 (PRINT NAME)

SAINI
SIGNATURE .....

TAREHE
DATE

Ikiwa mtu anayetia saini kwenye hati hii analazwa au kwa sasa yeye ni mgonjwa **hospitalini**, lazima mojawapo wa watu wafuatao atie saini na athibitishe kwamba amemwelezea mgonjwa maana na athari za mwelekezo wa mapema kuhusu matibabu na alionekana kwamba anaelewa na hakuwa ameshurutishwa au kushawishiwa wakati wa kutia saini: *mfafanuzi wa hospitali aliyeteuliwa, mchunguzi maalum, mwakilishi wa mgonjwa wa afya ya akili, kasisi anayetambuliwa, wakili wa Vermont, au Mteule wa Mahakama ya Uthibitisho.*

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.*

Ikiwa mtu anayetia saini kwenye hati hii analazwa au kwa sasa yuko katika **kituo cha utunzaji wa wazee au makazi ya utunzaji**, lazima mojawapo wa watu wafuatao atie saini na athibitishe kwamba amemwelezea mgonjwa maana na athari za mwelekezo wa mapema kuhusu matibabu na alionekana kwamba anaelewa na hakuwa ameshurutishwa au kushawishiwa wakati wa kutia saini: *mchunguzi maalum, kasisi anayetambuliwa, wakili wa Vermont, Mteule wa Mahakama ya Uthibitisho, mfafanuzi wa hospitali aliyeteuliwa, mwakilishi wa mgonjwa wa afya ya akili, daktari ambaye hajaajiriwa na kituo hicho, au mfanyakazi wa kujitolea aliyefunzwa ipasavyo wa kituo cha utunzaji wa wazee/makazi ya utunzaji.*

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.*

Mfafanuzi kama ilivyoelezwa hapa juu pia anaweza kutenda kama mojawapo wa mashahidi wawili wanaohitajika.

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

JINA
NAME

CHEO/KAZI
TITLE/POSITION

SIMU
PHONE

ANWANI
ADDRESS

SAINI
SIGNATURE .....

TAREHE
DATE

JINA NAME | **TAREHE YA KUZALIWA** DOB | **TAREHE** DATE

Watu wafuatao wana nakala ya Mwelekezo wangu wa Mapema kuhusu matibabu (tafadhali tia alama):

The following have a copy of my Advance Directive (please check):

☐ **Usajili wa Mwelekezo wa Mapema kuhusu matibabu wa Vermont** Vermont Advance Directive Registry **Tarehe iliyoandikishwa:** Date registered:

☐ **Wakala wa huduma ya utunzaji** Health care agent

☐ **Wakala mwingine wa huduma** Alternate health care agent

☐ **Daktari/Mtoa(Watoa) huduma:** Doctor/Provider(s):

☐ **Hospitali:** Hospital(s):

☐ **Mwanafamilia(Wanafamilia): Tafadhali orodhesha:** Family Member(s): Please list:

JINA NAME

ANWANI ADDRESS

JINA NAME

ANWANI ADDRESS

JINA NAME

ANWANI ADDRESS

JINA NAME

ANWANI ADDRESS

JINA NAME

ANWANI ADDRESS

☐ **Wengine:** Other:

JINA NAME

ANWANI ADDRESS

JINA NAME

ANWANI ADDRESS

JINA NAME

ANWANI ADDRESS

JINA NAME

ANWANI ADDRESS

JINA NAME

ANWANI ADDRESS

JINA NAME

ANWANI ADDRESS

VERMONT
DEPARTMENT OF HEALTH

Registry Use Only
Received: _____
Confirmed: _____

Usajili wa Mwelekezo wa Mapema kuhusu matibabu wa Vermont
Fomu ya Makubaliano ya Usajili na Idhini ya Kubadilisha
(Hati za A na B kulingana na Sheria ya Mwelekezo wa Mapema kuhusu matibabu wa Vermont)

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

Maelekezo / Directions

1. Soma Sera ya Usajili kwenye ukurasa wa 3 na ujaze sehemu muhimu hapa chini. Tafadhali andika au uchapishe kwa wazi.
   Read the Registration Policy on page 3 and complete the relevant sections below. Please type or print clearly.
   a. **Wasajili wa mara ya kwanza:** Jaza Taarifa ya Msajili Inayohitajika na Hati ya A.
      First-time Registrants: Complete the Required Registrant Information & Document A.
   b. **Kusasisha Mwelekezo wa Mapema kuhusu matibabu ulio kwenye faili:** Jaza Taarifa ya Msajili Inayohitajika na Hati ya B.
      Updating an Advance Directive already on file: Complete the Required Registrant Information & Document B.
2. Ambatisha nakala ya mwelekezo wa mapema kuhusu matibabu iliyotiwa saini na kushuhudiwa.
   Attach a signed and witnessed copy of your advance directive.
3. Usajili **lazima** ujumuishe Makubaliano wa Usajili uliokamilishwa na uliotiwa saini au Idhini ya Kubadilisha fomu na nakala ya mwelekezo wa mapema kuhusu matibabu iliyotiwa saini na kushuhudiwa.
   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. Baada ya fomu kukamilishwa na kutiwa saini, tuma fomu kwenye barua pepe, barua ya posta **au** faksi:
   Once forms are completed and signed, send forms by email, mail **or** fax:

Tuma barua pepe kwenye: VADRSubmissions@uslwr.com
E-mail to:

Au utume barua ya posta kwa: Vermont Advance Directive Registry (VADR)
Or Mail to: PO Box 2789
Westfield, NJ 07091-2789

Au Faksi kwa: 908- 654-1919
Or Fax to:

Kwa taarifa ya ziada tembelea: http://healthvermont.gov/vadr/ au piga simu 1-888-548-9455
For additional information visit: http://healthvermont.gov/vadr/ or call 1-888-548-9455

Taarifa za Msajili Zinazohitajika / Required Registrant Information

Jina: La kwanza _____ La kati _____ La mwisho _____ Kiambishi tamati _____
Name: First Middle Last Suffix

Tarehe ya Kuzaliwa: __ __ / __ __ / __ __ __ __
Date of Birth:

Anwani ya Msingi ya Kutumia Barua:
Primary Mailing Address: _____

Mji/Jiji: _____ **Jimbo:** _____ **Msimbo wa posta:** _____
Town/City: State: Zip code:

Nambari ya simu: Ya msingi: (__ __ __) __ __ __-__ __ __ __ Nyingine: (__ __ __) __ __ __-__ __ __ __
Phone Number: Primary Other:

Je, ungependa tuwasiliane na wewe kupitia barua pepe? ☐ **Hapana** ☐ **Ndiyo**
Would you like to be contacted by e-mail? No Yes

Anwani ya Barua Pepe:
Email Address: _____

Anwani ya Pili ya Kutumia Barua (ikiwa inahusika):
Secondary Mailing Address (if applicable): _____

Mji/Jiji: _____ **Jimbo:** _____ **Msimbo wa posta:** _____
Town/City: State: Zip code:

Wawasiliani wa Dharura / Emergency Contacts

Wa msingi: Jina:
Primary: Name: _____

Uhusiano na Msajili: _____ Nambari ya simu: (__ __ __) __ __ __-__ __ __ __
Relationship to Registrant: Phone Number:

Wa pili: Jina:
Secondary: Name: _____

Uhusiano na Msajili: _____ Nambari ya simu: (__ __ __) __ __ __-__ __ __ __
Relationship to Registrant: Phone Number:

VERMONT
DEPARTMENT OF HEALTH

Registry Use Only
Received: _____
Confirmed: _____

NOTISI: Mawasilisho yote kwa Usajili yanapaswa kujumuisha nakala iliyosainiwa na iliyoshuhudiwa ya Mwelekezo wa Mapema kuhusu matibabu wa Msajili. Hii inahusu mawasilisho yote ya kwanza na masasisho ya hati zilizopo.
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.

Hati ya A: Makubaliano ya Usajili
Document A: Registration Agreement

Jaza sehemu hii **tu** ikiwa hii ni mara yako ya kwanza ya kusajili mwelekezo wako wa mapema kuhusu matibabu.
Complete this section **only** if this is your first time registering your advance directive.

Mimi, _____ **(jina lililochapishwa)** ninaomba kwamba mwelekezo wangu wa mapema kuhusu matibabu usajiliwe katika Usajili wa Mwelekezo wa Mapema kuhusu matibabu wa Vermont, na ninakubali ufikiwe kama inavyoruhusiwa na sheria ya Vermont. Kwa kutia saini hapa chini, ninakubali na kuthibitisha kwamba: taarifa iliyotolewa ni sahihi; Nimesoma, nimeelewa, na ninakubaliana na masharti ya Sera ya Kujiandikisha kwenye Usajili; Nitalinda nambari yangu ya kitambulisho cha usajili na programu ya ununuzi ili isifikiwe na watu ambao hawajaidhinishwa; na nitajulisha Usajili haraka kwa maandishi kuhusu mabadiliko ya taarifa yangu ya usajili au mwelekezo wa mapema kuhusu matibabu. Nimekubali kwa hiari bila kulazimishwa, kushurutishwa, au kushawishiwa na mtu mwingine yeyote. Ninaelewa kwamba mtu yeyote anayeweza kufikia programu yangu ya ununuzi anaweza kuitumia kupata hati zangu na taarifa za kibinafsi. Idhini hii inatumika hadi nitakapoibatilisha.

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.

Saini ya Msajili: _____ **Tarehe:** _____
Signature of Registrant: **Date:**

Hati ya B: Idhini ya Kubadilisha
Document B: Authorization to Change

Jaza **tu** ikiwa umejisajili kwa sasa na unasasisha mwelekezo wa mapema kuhusu matibabu ambao upo kwenye faili na Usajili.
Complete **only** if you are currently registered and making updates to an advance directive already on file with the registry.

Tia alama kwenye kisanduku kilicho hapa chini kinachohusu uwasilishaji wako.
Check the box below that applies to your submission.

☐ **Rekebisha:** Tia alama kwenye kisanduku ili urekebishe mwelekezo wako wa mapema kuhusu matibabu uliopo. Historia ya hati ya awali itahifadhiwa kwenye faili yako.
Amend: Check this box to amend your existing advance directive. Prior document history will be retained in your file.

☐ **Badilisha:** Tia alama kwenye kisanduku hiki ili ubadilishe mwelekezo wako wa mapema kuhusu matibabu uliopo. Historia ya hati ya awali haitahifadhiwa kwenye faili yako.
Replace: Check this box to replace your existing advance directive. Prior document history will not be retained in your file.

☐ **Simamisha:** Tia alama kwenye kisanduku hiki ili ughairi sehemu yote au sehemu fulani ya mwelekezo wako wa mapema kuhusu matibabu kwa muda maalum uliobainishwa.
Suspend: Check this box to temporarily inactivate all or part of your advance directive for a defined period of time.

Tarehe ya Kuanza: _____ **Tarehe ya Kumaliza:** _____
Begin Date: End Date:

☐ **Batilisha:** Tia alama kwenye kisanduku hiki ili ufute mwelekezo wako wa mapema kuhusu matibabu kutoka kwenye Usajili. (Hii ni kuondoa kabisa kutoka kwenye Usajili)
Revoke: Check this box to delete your advance directive from the registry. (This is a permanent removal from the Registry)

Mimi, _____ **(jina lililochapishwa)** ninathibitisha kwamba fomu hii inawakilisha kwa usahihi mabadiliko ambayo nimefanya, na mabadiliko haya ni sahihi. Isitoshe, ninaidhinisha kwamba mabadiliko hayo yaonekane kwenye Usajili wa Mwelekezo wa Mapema kuhusu matibabu.

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.

Saini ya Msajili: _____ **Tarehe:** _____
Signature of Registrant: Date:

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DEPARTMENT OF HEALTH

Sera ya Usajili / Registration Policy

Mwelekezo wa Mapema kuhusu matibabu ni hati ya kisheria inayowasilisha matakwa ya mtu kuhusu matibabu yake na maamuzi yake kuhusu mwisho wa maisha endapo asijiweze au ikiwa hawezi kufanya maamuzi hayo. Usajili wa Mwelekezo wa Mapema kuhusu matibabu wa Vermont ni hifadhidata inayowaruhusu watu wahifadhi nakala yao ya mwelekezo wa mapema kuhusu matibabu kwenye hifadhidata salama. Hifadhidata hiyo inaweza kupatikana inapohitajika na wahudumu wa afya walioidhishwa, vituo vya huduma za afya, makazi ya huduma ya utunzaji, wakurugenzi wa mazishi, na waendeshaji wa tanuu ya kuchomea maiti. Kwa taarifa ya ziada tembelea: 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. Ili uandikishe mwelekezo wa mapema kuhusu matibabu, lazima msajili ajaze na atume fomu ya Makubaliano ya Usajili pamoja na nakala ya hati ya mwelekezo wa mapema kuhusu matibabu kwa:

   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. Baada ya kupokea makubaliano ya Usajili na viambatisho, Usajili utachanganua mwelekezo wa mapema kuhusu matibabu na kuuhifadhi kwenye hifadhidata pamoja na taarifa ya kumtambua msajili kutoka kwenye Makubaliano ya Usajili. Usajili utatumia msajili barua ya uthibitisho pamoja na nambari ya usajili, maelekezo ya kutumia nambari ya usajili kwa ajili ya kufikia hati kwenye tovuti ya Usajili, programu ya ununuzi, na vibandiko vya kubandika kwenye leseni ya dereva au kadi ya bima. Usajili hautumiki mpaka barua ya uthibitisho upokelewe na msajili amekamilisha nyenzo za usajili.

   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. Wasajili wanapaswa kushiriki nambari ya usajili kutoka kwenye programu ya ununuzi na mtu yeyote anayepaswa kufikia mielekezo ya mapema kuhusu matibabu: kwa mfano, wakala wa msajili, wanafamilia, au daktari. Mtu yeyote anaweza kufikia mwelekezo ya mapema kuhusu matibabu wa mtu mwingine kwa kutumia nambari ya usajili. Isitoshe, ikiwa nambari ya usajili haipatikani kwa urahisi, mhudumu wa afya aliyeidhinishwa anaweza kutafuta mwelekezo maalum wa mapema kuhusu matibabu kwenye Usajili kwa kutumia taarifa za kibinafsi za kumtambua msajili.

   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. Msajili ana jukumu la kuhakikisha kwamba:

   The registrant is responsible for ensuring that:

   a. Mwelekezo wa mapema kuhusu matibabu umetekelezwa vizuri kwa mujibu wa sheria za jimbo ya Vermont.

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

   b. Nakala ya mwelekezo wa mapema kuhusu matibabu iliyotumwa kwa Usajili, ikiwa ni nakala ya awali, ni sahihi na inaweza kusomwa.

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

   c. Taarifa iliyo katika Makubaliano ya Usajili na hati za mwelekezo wa mapema kuhusu matibabu ni sahihi na imesasishwa.

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

   d. Usajili unajulishwa haraka iwezekanavyo kuhusu mabadiliko yoyote kwenye mwelekezo wa mapema kuhusu matibabu au taarifa ya usajili kwa kukamilisha na kuwasilisha Idhini ya Kubadilisha fomu na mabadiliko yaliyoongezwa, au ikiwezekana, na nakala iliyosasishwa ya mwelekezo wa mapema kuhusu matibabu kwa Usajili.

      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. Usajili wa awali pamoja na mabadiliko yafuatayo na masasisho ya taarifa ya usajili au hati za mwelekezo wa mapema kuhusu matibabu hazilipishwi.

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

6. Makubaliano ya Usajili yataendelea kutumika mpaka Usajili upokee taarifa za kuaminika kwamba msajili amekufa, au msajili anaomba kwa maandishi kwamba Makubaliano ya Usajili yaishe. Makubaliano yanapoisha, Usajili utaondoa mwelekezo wa msajili wa mapema kuhusu matibabu kutoka kwenye hifadhidata ya Usajili, na watoa huduma hawatapata tena faili.

   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. Msajili tu ndiye anayeweza kubadilisha masharti ya Makubaliano ya Usajili.

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