NAME ..... DOB ..... DATE .....

# Advance Directive for Health Care

A Vermont Advance Directive Form in Plain Language

## INSTRUCTIONS

This is a legal form. You have the right to plan for health care decisions in advance. This form tells your friends, family, and health care providers what to do if you cannot speak for yourself.

This form has three parts:

**Part 1: Pick a health care agent (medical decision-maker)**

- This is someone you trust to make health care choices for you if you cannot.
- This person is your advocate. They speak for you to make sure that your values are respected.
- This person can also be called your durable power of attorney for health care or health care proxy.

**Part 2: Make your own health care choices**

- Write down your thoughts on medical treatments.
- This helps your health care agent and health care providers understand what matters to you.

**Part 3: Signing and witnessing the form**

- You must sign the form. Your signature must include the date.
- Two other adults also need to sign as witnesses.
- The witnesses cannot be your health care agent or your spouse, parent, child, brother, sister, or grandchild.

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

**You don't have to answer every question.**

If you skip something, draw a line through it.

**You must sign Part 3.**

NAME ..... DOB ..... DATE .....

# Part 1: Your Health Care Agent

## INSTRUCTIONS FOR PART 1

**Your health care agent's ability to make decisions for you generally starts when you cannot make them yourself.**

### A health care agent is someone who:

- Is 18 years of age or older
- Will listen when you talk about your values
- Can be there for you when you need them
- Will follow your values when making decisions
- You trust with your medical information
- Will not be afraid to ask questions
- Will speak up about your goals and preferences

### Unless they are a family member, your health care agent cannot be:

- Your health care providers
- An employee/owner of the hospital or clinic where you receive care
- An employee/owner of the residential care facility where you live

### If you cannot make decisions, your health care agent can:

- Participate in meetings as your advocate
- Access your medical information to make decisions
- Make any health care decisions that you could make if you were able

In Part 2, you will be able to tell your health care agent any decisions that you have already made for yourself. Your agent cannot change the choices that you make in your advance directive.

### What will happen if I do not choose a health care agent?

If you are not able to make your own decisions, your health care providers will ask people who know you well, or a guardian may be appointed to make decisions for you.

# Part 2: Your Health Care Choices

## INSTRUCTIONS FOR PART 2

**The choices you make in this document are a guide for your health care team. Discuss with your health care agent the choices you make here so they can advocate for you.**

### What kind of information should I put in Part 2?

· What you enjoy about life.
· What you are worried about for your future health.
· Experiences you have had with your health or treatments for your health.
· How you felt about treatment that friends and family members received in the past.
· Your goals if you cannot recover from your illness.
· Situations that would be unacceptable to you.

### What kinds of decisions can I make in Part 2?

· The kinds of treatments that you DO want to have.
· The kinds of treatments that you DO NOT want to have.
· Your willingness to try certain treatments.
· Where you would like to receive your care, if possible.

### Can anyone change what I say in this document?

No. You are the only person who can change the decisions that you make in your advance directive. You can change your mind at any time.

Your health care team is required to follow your instructions as closely as possible. Sometimes what you say in your directive will not be possible because of the medical situation. Your health care agent will help them to decide what to do if more guidance is needed.

### Can I skip questions?

Yes. You can skip any question that you do not want to answer by crossing it out. Please do not remove pages of the document. This way, it will be clear that you skipped those questions on purpose. You must sign Part 3.

### Will emergency responders follow this document?

No. Emergency responders do not look at advance directives. If they find this document posted on the refrigerator in your home, they may bring it with you to the hospital. Your health care providers at the hospital will read your advance directive to make a plan for your care with your health care agent. If you want a document that will stop emergency responders from doing CPR or other life-sustaining treatments, talk to your clinician about a **Do Not Resuscitate/ Clinician Order for Life-Sustaining Treatment (DNR/COLST).**

NAME ..... DOB ..... DATE .....

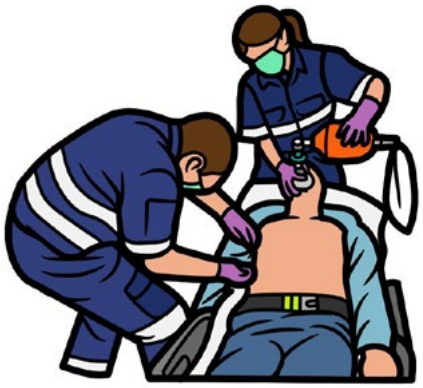
# Glossary of Health Care Treatments

**CPR** (cardio-pulmonary resuscitation)

**Cardio = heart | pulmonary = lungs | resuscitation = try to revive**

CPR involves:

- Pressing hard on your chest to keep blood pumping
- Electrical shocks to try to re-start your heart
- Medicines in your veins to keep blood moving
- Breathing support to get oxygen to your brain and other organs



## Breathing machine or Ventilator

This machine breathes for you. You are not able to talk when you are on the machine because a tube is placed in your throat to give air to your lungs.

## 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 can be placed through your nose down into your throat and stomach. It can also be placed by surgery into your stomach.

## Blood or fluid transfusions (IV – intravenous fluids or plasma)

To put blood and liquids into your body through your veins.

## Surgery

A procedure to remove or repair organs or tissues in your body to treat disease or injury. Also called an operation.

## Medicines

Drugs (pills, liquids, or injections) given to treat illness.

## Antibiotics

A drug that fights infections. Antibiotics need to be taken for a specific number of days to work completely.

## Palliative Care

Medical care that focuses on relieving pain, symptoms and stress caused by serious illness. Palliative care helps with pain and symptoms instead of trying to cure illness.

## Hospice Care

A type of palliative care that is available for the last six months of life. It helps people to live well until they die. It focuses on pain relief, symptom management, and emotional support for patients with terminal illness and their families.

# Advance Directive for Health Care

A Vermont Advance Directive Form in Plain Language

**My Name:** _____

**My Date of Birth:** _____

**My Address:** _____

**My Phone Number:** _____

**I am completing my advance directive on this date:** _____

**This is a legal form.** You have the right to make your own health care decisions. This form tells your friends, family, and health care providers what matters to you if you cannot speak for yourself.

You can fill out just Part 1, just Part 2, or both. You don't have to answer every question. If you skip something, draw a line through it.

**You must sign in Part 3.**

**All pages need to include:**

- Your name
- Your date of birth
- The date you are completing this form

**After your advance directive is signed, dated, and witnessed, make copies for:**

- Yourself
- Your health care agent
- Your health care providers/hospital
- Other people that you want to know your values (friends, family, etc.)
- The Vermont Advance Directive Registry (Registration is recommended. The form to register is attached at the end of this document)

# Part 1: Your Health Care Agent

Who do you trust to make your medical decisions if needed?

Your health care agent is the person you choose to make medical decisions for you if you cannot speak for yourself. Talk to this person before you appoint them.

## Primary Health Care Agent

I want this person to be my health care agent if I cannot make my own decisions:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone 1: _____ Phone 2: _____

## Alternate Health Care Agent

If the first person is not able, I want this person to make my decisions:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone 1: _____ Phone 2: _____

**Other people who know me well. They can receive or share information if needed:**

**I do NOT want these people to make medical decisions for me:**

NAME ..... DOB ..... DATE .....

# Part 2: Your Health Care Choices

About You and Your General Health Care Values:

**What does a good day look like for you?**

Here are some things I enjoy doing on a good day:

**What does a hard day look like for you?**

Here are some things that are hard for me on a tough day:

**What are your fears or concerns about your health in the future?**

Here are some things I feel scared or nervous about:

**What are your most important goals if your health situation gets worse?**

Here are some things I still want to do, even if my health changes:

**What would be an unacceptable quality of life for you?**

# Part 2: Your Health Care Choices

## About You and Your General Health Care Priorities

**What is important in your life?** *Check all that apply to you.*

- ☐ Interactions with family or friends: _____
- ☐ Your pets: _____
- ☐ Hobbies, like gardening, hiking, or reading
  My hobbies: _____
  _____
- ☐ Working or volunteering: _____
- ☐ Taking care of myself (eating, bathing, dressing, using the bathroom)
- ☐ Living independently
- ☐ Religion or spirituality
  Your faith: _____
- ☐ Something else: _____
  _____

**As a patient, I'd like to know ...**

- ◯ Only the basics about my condition and treatment
- ◯ All the details about my condition and treatment

**If you had a serious illness, would you want your health care providers to tell you how sick you are or how long you may have to live?**

- ◯ Yes, I would want to know this information
- ◯ No, I would not want to know. Please talk to my health care agent instead.

*Tell your health care providers how you want to get information.*

# Part 2: Your Health Care Choices

## About You and Your General Health Care Priorities

Your health care agent will use the information in this section to discuss the treatment options with your health care providers. This will help them know what you would think about your health situation.

**Which of these conditions would NOT be acceptable for you?** *Check all that apply.*

- ☐ If I were unable to wake up (vegetative state, coma)
- ☐ If I were unable to communicate with my family and friends
- ☐ If I were unable to live without being connected to machines
- ☐ If I were unable to think for myself (such as severe dementia)

  *Dementia (example: Alzheimer's disease) affects the brain. Over time these conditions cause memory loss, mood changes, and confusion with thinking and daily tasks.*
- ☐ If I were unable to feed, bathe, or take care of myself
- ☐ If I were unable to live on my own, such as in a nursing home
- ☐ If I was in constant pain
- ☐ Something else: _____

**What else should your medical providers and health care agent know to be able to take good care of you?**

**What else would matter to you if you were very sick? (such as food, music, pets, or people you want around you.)**

*If you have questions about your health, talk with your health care provider. You can share the information you get with your health care agent. If you want, you can also include your health care agent in conversations that you have with your health care providers.*

# Part 2: Your Health Care Choices

## End-of-life Care Preferences

Treatments for serious, irreversible illness come with tradeoffs. Some people are willing to go through a lot for a chance to live longer. Some people do not want certain treatments if they cannot get better. Life-support treatment can be **CPR**, a **breathing machine**, **feeding tubes**, **dialysis**, **certain medications**, or **transfusions**.

**What are your concerns about medical treatment near end-of-life?**

**If you were so sick that your health care providers think you may die, what would you say?**
*Check the one choice you most agree with.*

- ◯ **Try all life-support treatments that health care providers think might help me live as long as possible.** I am willing to be in the hospital for an extended period of time. I want to try any treatment that could give me more time.
- ◯ **Try life-support treatments for a short period of time. See if they help. Then decide whether to continue them.** I want my agent to work with my health care team to decide how long to continue treatments.
- ◯ **I do not want treatments to extend my life if I will not get better.** I prefer a natural death. I want to be kept as comfortable as possible through the dying process.

**Add more about your views on medical treatment if you were approaching end-of life.**
*If you are attaching more pages to your advance directive, please list them here.*

*NOTE: Assistance with eating by mouth is not treatment. If there are situations when you would not want assistance to eat by mouth, discuss this with your health care agent and medical providers.*

# Part 2: Your Health Care Choices

Organ Donation & Funeral/Disposition of Remains

## Organ Donation

**Would you like to donate any organs or tissues after death?**

◯ I want to donate my organs or body parts.

If you would like to donate, which organs or body parts do you want to donate?

☐ Any organ or body part

☐ Only the following: _____

◯ I do not want to donate my organs or body parts.

◯ I have made arrangements to donate my body to medical research.

## Funeral and Disposition of Remains

**Who do you want to make decisions about your body, funeral, and disposition of remains?**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone 1: _____ Phone 2: _____

**If you have a pre-arranged funeral agreement, list that information here:**

Funeral Home: _____

Phone Number or Email: _____

**Describe any specific wishes that you have for treatment of your body after you die, funeral, and burial.**

# Part 3: Signing and Witnessing

Sign, date and witness this form to make it a legal Vermont advance directive.

## MY SIGNATURE

*I confirm that this advance directive represents my preferences for my health care. I am signing this document of my own free will.*

Signature:_____ Date: _____

Name (print):_____

## WITNESS SIGNATURES

Witnesses must be at least 18 years old. Witnesses **cannot** be your health care agent, spouse, parents, siblings, children, or grandchildren.

### Witness #1

*I agree that the person completing this advance directive understood what they were signing and is signing this directive of their own free will.*

Signature:_____ Date: _____

Name of Witness #1 (print): _____

### Witness #2

*I agree that the person completing this advance directive understood what they were signing and is signing this directive of their own free will.*

Signature:_____ Date: _____

Name of Witness #2 (print):_____

**If you are completing this advance directive while you are a patient at a hospital, nursing home or residential care facility, your advance directive must be reviewed with you and signed by an explainer.** The explainer signs on the next page.

# Part 3: Signing and Witnessing

Explainer Signature *(ONLY for patients in a hospital or other health care facilities)*

**If you are in a hospital or other health care facility, Vermont law requires that an explainer talk about the advance directive with you to make sure that you understand your choices.**

**Hospital explainers can be:**

- An ombudsman
- A mental health patient representative
- A member of the clergy
- An attorney licensed in Vermont
- A designated member of the probate court
- A designated explainer from the hospital

**If you are in a nursing home or residential care facility, explainers can also be:**

- A trained volunteer
- A clinician (doctor or nurse) not employed by the nursing home or residential facility
- Any of the hospital explainers listed above

**The explainer can also serve as one of the witnesses on page 8.** If they are serving as a witness, the explainer should sign below and in the witness section on page 8.

Signature:_____

Explainer Name: _____ Date: _____

Title/Postion: _____ Phone: _____

Facility / Organization: _____

Email Address: _____

# Other Important Contacts

My Health Care Team & Other People with Copies of My Directive:

## My Health Care Providers:

**Name:** _____

Practice / Facility: _____

Phone: _____ Email: _____

**Name:** _____

Practice / Facility: _____

Phone: _____ Email: _____

**Name:** _____

Practice / Facility: _____

Phone: _____ Email: _____

## The following people also have a copy of my advance directive:

**Name:** _____

Practice / Facility: _____

Phone: _____ Email: _____

**Name:** _____

Practice / Facility: _____

Phone: _____ Email: _____

**Name:** _____

Practice / Facility: _____

Phone: _____ Email: _____

**Name:** _____

Practice / Facility: _____

Phone: _____ Email: _____

VERMONT
DEPARTMENT OF HEALTH

**Registry Use Only**
Received: _____
Confirmed: _____

# Vermont Advance Directive Registry
## Administrative Form: VADR Registration Agreement & Authorization to Change
(Documents A & B per Vermont Advance Directive Rule)

### Directions

1. Read the **Registration Policy on page 3** and complete the **Required Registrant Information on page 1**.
   a. **First-time Registrants:** Complete **Document A: Registration Agreement on page 2**.
   b. **Current Registrants:** If you are already registered and submitting an update, complete **Document B: Authorization to Change on page 2.**
2. Attach a signed and witnessed copy of your Advance Directive. *Witnesses to your Advance Directive cannot be your health care agent or immediate family (spouse, parents, children, siblings or grandchildren).*
3. Submissions via mail, email, or fax must include pages 1 and 2 of this Administrative Form and all pages of your completed Advance Directive.
4. Once complete, forms can be submitted via mail, email, or fax:

**Mail:** Vermont Ethics Network
61 Elm Street, Suite 1
Montpelier, VT 05602

**Fax:** 1-802-828-2646
**Email*:** VADRSupport@vtethicsnetwork.org
**Email submissions must be in PDF format.*

Vermont registrants can now also submit new registrations or updates via on-line user upload. User upload does not require this administrative form. For more information and links to upload your document from your home computer, visit www.vtethicsnetwork.org/vadr. **For support with your submission, call 1-802-828-2909 or email VADRSupport@vtethicsnetwork.org**

### Required Registrant Information

**Name:** First: Middle: Last: Suffix:

**Date of Birth:** / / (month/day/year)

**Mailing Address:** **Apt/Unit:**

**Town/City:** **State:** **Zip Code:**

**Phone Number:** Primary ( ) - Other ( ) -

**Email Address:**

***Registrants must provide an email address to receive annual account reminders.*

### Emergency Contacts

*Please list cell number first if available*

**Primary:** Name: **Relationship to Registrant:**

**Phone Number:** ( ) - Alternate Phone Number: ( ) -

**Secondary (optional):** Name: **Relationship to Registrant:**

**Phone Number:** ( ) -

**Note:** *Emergency contacts do not need to be the same as your appointed health care agents. Changing your emergency contacts will not change your health care agent.*

VERMONT
DEPARTMENT OF HEALTH

**Registry Use Only**
Received: _____
Confirmed: _____

**Vermont Advance Directive Registry**
**Administrative Form: VADR Registration Agreement & Authorization to Change**
(Documents A & B per Vermont Advance Directive Rule)

**Document A: Registration Agreement**

*Complete this section if this is your first time submitting an Advance Directive to the Vermont Advance Directive Registry.*

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.

**Signature of Registrant:** _____ Date: _____

**Document B: Authorization to Change**

*Complete this section if you are currently registered and submitting an updated Advance Directive or making updates to an Advance Directive already on file with the Vermont Advance Directive Registry.*

**Check the box below that applies to your submission**.

☐ **Replace:** Check this box to replace your existing Advance Directive. This option will remove older documents from your account and save only the most recent submission.

☐ **Amend:** Check this box to amend your existing Advance Directive. This option will keep your prior documents on file with the newest document first (reverse chronological order).

☐ **Suspend:** Check this box to temporarily inactivate all or part of your Advance Directive for a specified period.

Begin suspension on this date: _____
End suspension on this date: _____
Suspension details (parts of Advance Directive being suspended, reason for suspension):
_____

☐ **Revoke:** Check this box to remove your Advance Directive from the Vermont Advance Directive Registry. Your account with the Vermont Advance Directive Registry will be closed and your document will not be accessible to health care facilities. Your Advance Directive will remain valid.

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 Vermont Advance Directive Registry.

**Signature of Registrant:** _____ **Date:** _____

VERMONT
DEPARTMENT OF HEALTH

**Registry Use Only**
Received: _____
Confirmed: _____

**Vermont Advance Directive Registry**
**Administrative Form: VADR Registration Agreement & Authorization to Change**
(Documents A & B per Vermont Advance Directive Rule)

## Registration Policy

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. To register an advance directive via mail, fax, or email, the registrant must complete and send the Registration Agreement form along with a copy of the advance directive document to:

   **Mail:**
   Vermont Ethics Network,
   61 Elm Street, Suite 1
   Montpelier, Vermont 05602

   **Fax:** 1-802-828-2646

   **Email:** VADRSupport@vtethicsnetwork.org
   **Email submissions must be in PDF format*

2. Registrants who upload their document via user upload do not need to complete the Registration Agreement or Authorization to Change form. The necessary agreements and authorization will be completed during the on-line upload process.
3. 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.
4. 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.
5. The registrant is responsible for ensuring that:
   a. The advance directive is properly executed in accordance with the laws of the state of Vermont.
   b. The copy of the advance directive sent to the Registry, if a photocopy of the original, is correct and readable.
   c. The information in both the Registration Agreement and advance directive documents is accurate and up to date.
   d. 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.
6. Initial registration as well as subsequent changes and updates to the registration information or the advance directive documents are free of charge.
7. 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.
8. Only the Registry can change the terms of the Registration Agreement.