Pennsylvania Advance Healthcare Directive

(which includes Living Will and Healthcare Power of Attorney)

This form lets you have a say about how you want to be cared for if you are unable to speak for yourself. By completing Parts 1, 2 and 3 entirely, you will have both Living Will and Healthcare Power of Attorney legal documents.

This form has 3 parts:

1 **Choose a medical decision-maker — page 3**

A medical decision-maker is a person who can make healthcare decisions for you if you are unable to make them yourself. This person will be your advocate. They are also called a healthcare agent, proxy representative, and/or surrogate or Healthcare Power of Attorney.

2 **Make your own healthcare choices — page 7**

This form lets you choose the kind of healthcare you want if you can no longer speak for yourself. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself. This is also called a Living Will.

3 **Sign the form — page 13**

This form must be saved, printed, and signed before it can be used.*

*Pennsylvania law does not require this document to be notarized, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other states.

AHN

Your name _____

Date of birth (MM/DD/YYYY) _____

This is a legal form that lets you have a voice in your healthcare.
It will let your family, friends, and medical providers know how you want to be cared for if you cannot speak for yourself.

What should I do with this form?

- Share this form with your family, friends, and medical providers.
- Make sure copies of this form are placed in your medical record at all the places you get care.

What if I have questions about the form?

- Ask your doctors, nurses, social workers, family, or friends to help.
- Lawyers can help too. This form does not give legal advice.
- It is important to have your questions answered before you complete the form.

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

- On page 11, you can write down anything else that is important to you.

When should I fill out this form again?

- If you change your mind about your healthcare choices
- If your health changes
- If your medical decision-maker changes

If your spouse is your decision-maker, and you divorce, that person will no longer be your decision-maker, unless you name them.

Give the new form to your medical decision-maker and medical providers.

Destroy old forms.

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

Your name _____

Date of birth (MM/DD/YYYY) _____

Part 1 Choose your medical decision-maker (Heathcare Power of Attorney)

Your medical decision-maker can make healthcare decisions for you if you're unable to make them yourself, or if you haven't already made these decisions. For the purposes of this form, this person will be your Healthcare Power of Attorney.

A good medical decision-maker is a family member or friend who:

- Is 18 years of age or older.
- Can talk to you about your wishes.
- Can be there for you when you need them.
- You trust to follow your wishes and do what's best for you.
- You trust to know your medical information.
- Is not afraid to ask doctors questions and speak up about your wishes.

Legally, your decision-maker cannot be your doctor or someone who works at your hospital or clinic, unless they are a family member.

What will happen if I don't choose a medical decision-maker?

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

If you are not able, your medical decision-maker can choose these things for you:

- Who will care for you (doctors, nurses, social workers, or caregivers).
- Where you will receive care (hospitals, clinical, nursing homes).
- What treatments you will receive (medications, tests, or treatments).
- Who can look at your medical information, and who can visit you while you are hospitalized.
- What happens to your body and organs after you die.

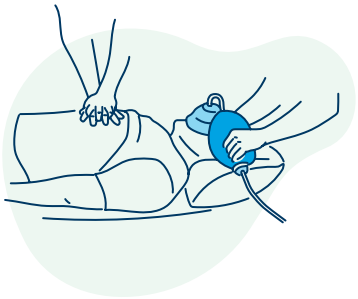
AHN

Your name _____

Date of birth (MM/DD/YYYY) _____

Here are more decisions your medical decision-maker can make:

Start or stop life support or medical treatments, such as:



CPR or cardiopulmonary resuscitation

C cardio = heart P pulmonary = lungs R resuscitation = try to bring back

This may involve:

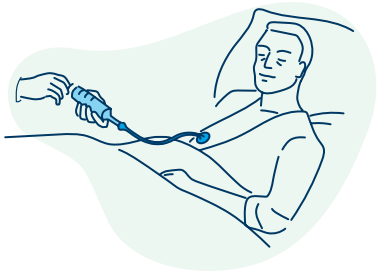
- Pressing hard on your chest to try to keep your blood pumping.
- Electrical shocks to try to jump start your heart.
- Putting medicine into your veins.

Breathing machine or ventilator

This machine pumps air into your lungs and tries to breathe for you. You are not able to talk when you are on the machine.

Dialysis

This machine tries to clean your blood if your kidneys stop working.



Feeding tube

This is a tube used to try 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 and water transfusions (IV)

To put blood and water into your body.

Surgery

Medicines

End-of-life decisions your medical decision-maker can make:

- Decide to call in a religious or spiritual leader
- Decide if you die at home or in the hospital
- Decide about autopsy or organ donation
- Decide about burial or cremation

AHN

Your name _____

Date of birth (MM/DD/YYYY) _____

1

Who is your decision-maker? (Must be same person listed on page 12, #1)

If you want, you can write why you chose your medical decision-maker(s).

Write down anyone you would NOT want to help make medical decisions for you.

How strictly do you want your medical decision-maker to follow your wishes if you are not able to speak for yourself?

Flexibility allows your decision-maker to change your prior decisions if doctors think something else is better for you at that time. Prior decisions may be wishes you wrote down or talked about with your medical decision-maker. You can write your wishes in Part 2 of this form.

Check the one choice you most agree with:

- ☐ Flexibility: It is OK for my decision-maker to change any of my medical decisions if my doctors think it is best for me at that time.
- ☐ No Flexibility: I want my decision-maker to follow my medical wishes exactly. It is NOT OK to change my decisions, even if the doctors recommend it.

If you want, you can write why you feel this way.

To make your own healthcare choices, go to Part 2 on page 6.
When you are done, you must complete Part 3, which begins on page 12 and ends on page 14.

Please share your wishes with your family, friends, and medical providers.

AHN

Your name _____

Date of birth (MM/DD/YYYY) _____

Part 2 Make your own healthcare choices (Living Will)

Answer the questions that matter most to you. For purposes of this form, this will serve as your Living Will.

Some people prefer to make their own medical decisions. Some people prefer input from others (family, friends, and medical providers) before they make a decision. And, some people prefer other people make decisions for them.

Note: Medical providers cannot make decisions for you. They can only give information to help with decision-making.

How do you prefer to make medical decisions?

- ☐ I prefer to make medical decisions on my own without input from others.
- ☐ I prefer to make medical decisions only after input from others.
- ☐ I prefer to have other people make medical decisions for me.

If you want, you can write why you feel this way, and who you want input from.

_____

What matters most in life? Quality of life differs for each person.

What is most important in your life? Check as many as you want.

- ☐ Your family or friends
- ☐ Your pets
- ☐ Hobbies, such as gardening, hiking, and cooking
- ☐ Working or volunteering
- ☐ Caring for yourself and being independent
- ☐ Not being a burden on your family
- ☐ Religion or spirituality
  Your religion: _____
- ☐ Something else: _____

What brings joy to your life? What are you most looking forward to in life?

_____

AHN

Your name _____

Date of birth (MM/DD/YYYY) _____

2

What matters most for your medical care? This differs for each person.

For some people, the main goal is to be kept alive as long as possible, even if:

- They have to be kept alive on machines and are suffering.
- They are too sick to talk to their family and friends.

For other people, the main goal is to focus on quality of life and being comfortable.

- These people would prefer a natural death, and not be kept alive on machines.

Other people are somewhere in between. What is important to you?
Your goals may differ today in your current health than at the end of life.

AT THE END OF LIFE

Check one choice to show how you would feel if you were so sick that you may die soon:

☐ I prefer to make medical decisions on my own without input from others.

☐ I prefer to make medical decisions only after input from others.

If you want, you can write why you feel this way.

Quality of life differs for each person at the end of life. What would be most important to you? Write down your choices so those who care for you will not have to guess.

AT THE END OF LIFE

Some people are willing to live through a lot for a chance of living longer. Other people know that certain things would be very hard on their quality of life.

- Those things may make them want to focus on comfort rather than trying to live as long as possible.

At the end of life, which of these things would be very hard on your quality of life?

Check as many as you want:

- ☐ Being in a coma and not able to wake up or talk to my family and friends
- ☐ Not being able to live without being hooked up to machines
- ☐ Not being able to think for myself, such as severe dementia
- ☐ Not being able to feed, bathe, or take care of myself
- ☐ Not being able to live on my own, such as in a nursing home
- ☐ Having constant, severe pain or discomfort
- ☐ Something else: _____
- ☐ **OR**, I am willing to live through all of these things for a chance of living longer.

If you want, you can write why you feel this way.

_____

What experiences have you had with serious illness or with someone close to you who was very sick or dying? If you want, you can write down what went well or did not go well.

_____

If you were dying, where would you want to be?

☐ At home ☐ In the hospital ☐ Either

What else would be important, such as food, music, pets, or people you want around you?

_____

How do you balance quality of life with medical care?

Sometimes illness and the treatments used to try to help people live longer can cause pain, side effects, and the inability to care for yourself.

Please read this whole page before making a choice.

AT THE END OF LIFE, some people are willing to live through a lot for a chance of living longer. Other people know that certain things would be very hard on their quality of life.

Life support treatment can be CPR, a breathing machine, feeding tubes, dialysis, or transfusions.

Check the one choice you most agree with.

If you were so sick that you may die soon, what would you prefer?

- ☐ Try all life support treatments that my doctors think might help. I want to stay on life support treatments even if there is little hope of getting better or living a life I value.
- ☐ Do a trial of life support treatments that my doctors think might help. But, I DO NOT want to stay on life support treatments if the treatments do not work and there is little hope of getting better or living a life I value.
- ☐ I do not want life support treatments, and I want to focus on being comfortable. I prefer to have a natural death.
- ☐ I want my medical decision-maker to decide for me.

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

What else should your medical providers and decision-maker know about this choice? Or, why did you choose this option?

_____

Your name _____

Date of birth (MM/DD/YYYY) _____

Your decision-maker may be asked about organ donation and autopsy after you die. Please tell us your wishes.

ORGAN DONATION

Some people decide to donate their organs or body parts. What do you prefer?

☐ I want to donate my organs or body parts.

Which organ or body part do you want to donate?

- ☐ Liver, kidneys, heart, lung, etc.: _____
- ☐ Other body parts: face, limbs, facial tissue, other vascularized allografts (this requires separate consent that is not supplied here; checking this box is not sufficient legal consent)
- ☐ Only: _____

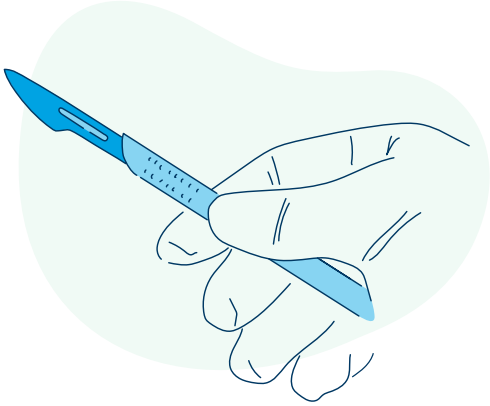
☐ I do not want to donate my organs or body parts.

What else should your medical providers and medical decision-maker know about donating your organs or body parts?

_____

AUTOPSY

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



☐ I want an autopsy.

☐ I do not want an autopsy.

☐ I only want an autopsy if there are questions about my death.

☐ I want my medical decision-maker to decide for me.

Pennsylvania law may override your choice.

AHN

Your name _____

Date of birth (MM/DD/YYYY) _____

2

FUNERAL OR BURIAL WISHES

What should your medical providers and decision-maker know about how you want your body to be treated after you die, and your funeral or burial wishes?

Do you have religious or spiritual wishes? _____

Do you have funeral or burial wishes? _____

What else would you like to share about you and your medical choices?

CONSIDER how much of your medical information you wish to know:

Some people may want to know all of their medical information. Other people may not.

If you had a serious illness, would you want your doctors and medical providers to tell you how sick you are?

- ☐ Yes, I would want to know this information.
- ☐ No, I would not want to know. Please talk with my decision-maker instead.

Talk to your medical providers so they know whether you want to get information about your condition(s), diagnosis, and/or prognosis.

Part 3 Sign the form (Remember to complete Parts 1 and 2)

Choose your medical decision-maker:
Write the name of your medical decision-maker (Healthcare Power of Attorney).

1 I want this person to make my medical decisions if I am not able to make my own:
(This must be the same person listed on page 5 of this form.)

First name _____ Last name _____

Phone #1 _____ Phone #2 _____ Relationship _____

Address _____ City _____ State _____ ZIP code _____

2 If the first person cannot do it, then I want this person to make my medical decisions:

First name _____ Last name _____

Phone #1 _____ Phone #2 _____ Relationship _____

Address _____ City _____ State _____ ZIP code _____

By signing this form, you allow your medical decision-maker to:

- Agree to, refuse, or withdraw any life support or medical treatment if you are not able to speak for yourself.
- Decide what happens to your body after you die, such as funeral plans and organ donation.

If there are decisions you do not want them to make, write them here:

_____

When can my medical decision-maker make decisions for me?

☐ ONLY after I am not able to make my own decisions

☐ NOW, right after I sign this form

AHN

Your name _____

Date of birth (MM/DD/YYYY) _____

3

Before this form can be used, you must:

- Sign this form if you are 18 years of age or older.
- Have two witnesses who can watch you sign this form.

Sign your name and write the date:

Sign your name _____ Today's date _____

Print your first name _____ Print your last name _____ Date of birth _____

Address _____ City _____ State _____ ZIP code _____

Witnesses

Before this form can be used, you must have two (2) witnesses sign the form.

Your witnesses must:

- Be 18 years of age or older.
- See you sign the form.

Your witnesses cannot:

- Be the person that signed this form for you.
- Be your medical decision-maker.
- Be your healthcare provider (your doctor, nurse, physician's assistant, etc.).

It is recommended that your witnesses NOT:

- Work for your healthcare provider; or
- Work at the place where you live.

Witnesses need to sign their names on page 14.

AHN

Your name _____

Date of birth (MM/DD/YYYY) _____

3

Have your witnesses sign their names and write the date.

By signing, I promise that_____signed this form while I watched.
The person named on page 13

They were thinking clearly and were not forced to sign it. I also promise that:

- I am 18 years of age or older.
- I am not a medical decision-maker for this person.

Witness 1

Sign your name Date

Print your first name Print your last name

Address City State ZIP code

Witness 2

Sign your name Date

Print your first name Print your last name

Address City State ZIP code

Notarization (Optional)
On this_____day of_____, 20_____, before me personally appeared the aforesaid declarant and principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed. IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of_____, State of _____the day and year first above written.

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

AHN

Your name _____

Date of birth (MM/DD/YYYY) _____

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