Rosewood
HEALTHCARE
& MEDICAL SPA

Advanced Directive Form

This form is a combined durable power of attorney for health care and a living will (in some jurisdictions). With this form, you can name someone to make medical decisions for you if in the future you're unable to make those decisions yourself. You can also say what medical treatments you want and what treatments you do not want if in the future you're unable to make those wishes known.

Instructions

Read each section carefully. Before you fill out the form, talk to the person you want to name, to make sure that he/she understands your wishes and is willing to take the responsibility. Write your initials in the blank spaces before the choices you want to make. Write your initials only beside the choices you want under parts 1, 2, and 3 of this form. Your advance directive should be valid for whatever part(s) you fill in, as long as it is properly signed.

Add any special instructions in the blank spaces provided. You can write additional comments on a separate sheet of paper, but you should write on this form that there are additional pages to your advanced directive. Sign the form and have it witnessed. Give copies to your doctor, your nurse, the person you name to make your medical decisions for you, people in your family and anyone else who might be involved in your care. Discuss your advance directive with them.

Understand that you may change or cancel this document at any time.

Definitions to Know

Advance directive- a written document (form) that tells what a person wants or does not want if he/she in the future can not make their own wishes known about medical treatment.

Artificial nutrition and hydration- when food and water are fed to a person through a tube.

Autopsy- an examination done on a dead body to determine the cause of death

Comfort care- care that helps to keep a person comfortable but does not make them get well. For example bathing, turning, and keeping a person's lips moist.

CPR(cardiopulmonary resuscitation)- treatment to try to restart a person's breathing or heartbeat. CPR may be done by pushing on the chest, by putting a tube down the person's throat or by other treatments.

Durable power of attorney for health care- an advance directive that names someone to make medical decisions for a person if in the future he/she can not make their own medical decisions.

Life-sustaining treatment- Any medical treatment that is used to keep a person from dying. For example a breathing machine, CPR, and artificial nutrition.

Living Will- An advance directive that tells what medical treatment a person does or does not want if they are unable to make their own wishes known.

Organ and tissue donation- when a person permits their organs (such as eyes, kidneys, and heart) as well as other body parts such as skin to be removed after death to be transplanted for use by another person or to be used for experimental purposes.

Persistent vegatative state- when a person is unconscious with no hope of regaining consciousness even with medical treatment. The body may move and the eyes may be open, but as far as anyone can tell, the person can not think or respond.

Terminal condition- an ongoing condition caused by injury or illness that has no cure and from which doctors expect the person to die even with medical treatment. Life-sustaining treatments will only prolong the dying process if the person is suffering from a terminal condition.

We at Rosewood Health Care are here to help you.
Please let us know if you have any questions.

Complete this portion of the advance directive form

I,_____, write this document as a directive regarding my medical care.

In the following sections, put your initials in the blank spaces by the choices you want.

PART 1.

My Durable Power of Attorney for Health Care

_____ I appoint this person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself. I want the person I have appointed, my doctors, my family and others to be guided by the decisions I have made in the parts of the form that follow.

Name: _____
Home Phone:_____
Work Phone:_____
Address:_____
_____

If the above person cannot or will not make decisions for me, I appoint this person:

Name: _____
Home Phone:_____
Work Phone:_____
Address:_____
_____

_____ I have not appointed anyone to make health care decisions for this.

PART 2

My Living Will

These are my wishes for my future medical care if there ever comes a time when I can not make these decisions for myself.

A. These are my wishes if I have a terminal condition.

Life-sustaining treatments

_____ I do not want life-sustaining treatment(including CPR) started. If life sustaining treatments are started, I want them stopped.
_____ I want the life-sustaining treatments that my doctors think are best for me.
_____ Other wishes: _____
_____

Artificial nutrition and hydration

_____ I do not want artificial nutrition and hydration started if they would be the main treatments keeping me alive. If artificial nutrition and hydration are started, I want them stopped.
_____ I want artificial nutrition and hydration even if they are the main treatments keeping me alive.
_____ Other wishes _____
_____

Comfort Care

_____ I want to be kept as comfortable and free of pain as possible, even if such prolongs my dying or shortens my life.
_____ Other wishes _____
_____

B. These are my wishes if I am ever in a persistent vegatative state.

Life-sustaining treatments

_____ I do not want life-sustaining treatment(including CPR) started. If life sustaining treatments are started, I want them stopped.
_____ I want the life-sustaining treatments that my doctors think are best for me.
_____ Other wishes: _____
_____

Artificial nutrition and hydration

_____ I do not want artificial nutrition and hydration started if they would be the main treatments keeping me alive. If artificial nutrition and hydration are started, I want them stopped.
_____ I want artificial nutrition and hydration even if they are the main treatments keeping me alive.
_____ Other wishes _____
_____

Comfort Care

_____ I want to be kept as comfortable and free of pain as possible, even if such prolongs my dying or shortens my life.
_____ Other wishes _____
_____

C .Other directions

You have the right to be involved in all decisions about your medical care, even those not dealing with terminal conditions or persistent vegatiative states. If you have wishes not covered in other parts of this document, please indicate them below

Other statements about your medical care

If you wish to say more about any of the choices you have made or if you have any other statements to make about your medical care, you may do so on a seperate piece of paper. If you do so, put here the number of pages you are adding:_____

PART 3
Signatures

You and your two witnesses must sign this document before it will be legal.

A Your signature

By my signature below, I show that I understand the purpose and the effect of this document.

Signature:_____ Date:_____
Address:_____
_____

B Your Witnesses' Signatures

I believe the person who has signed this document to be of sound mind, that he/she signed or acknowledged this advance directive in my presence and that he/she appears not to be acting under pressure, duress, fraud or undue influence. I am not related to the person making this advance directive by blood, marriage or adoption nor, to the best of my knowledge, am I named in his/her will. I am not the person appointed in this advanced directive. I am not a health care provider or an employee of a health care provider who is now, or has been in the past, responsible for the care of the person making this advanced directive.

Witness #1

Signature:_____ Date:_____
Address:_____
_____

Witness #2

Signature:_____ Date:_____
Address:_____
_____