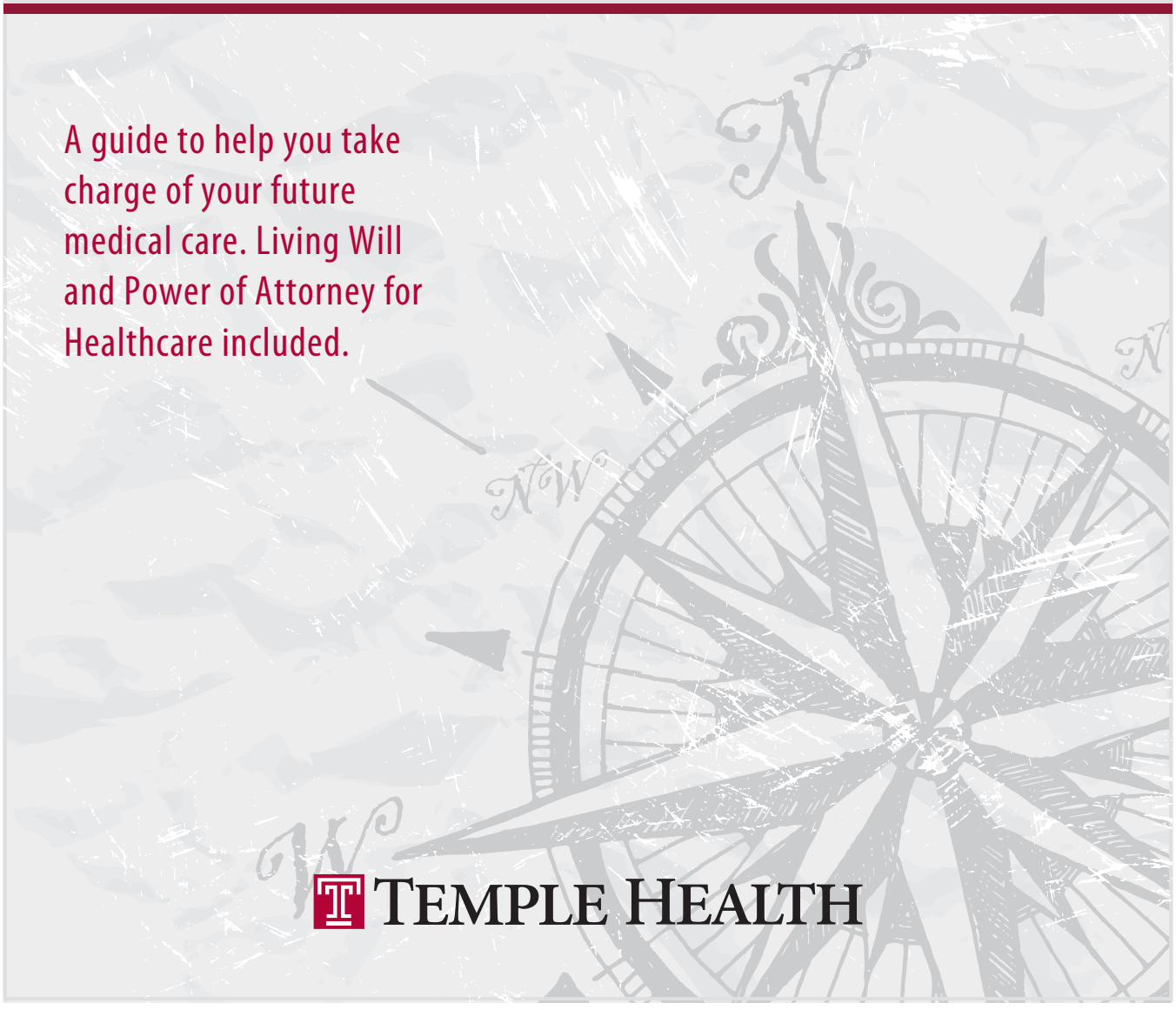
ADVANCE DIRECTIVE

Your Choice, Your Voice

A guide to help you take charge of your future medical care. Living Will and Power of Attorney for Healthcare included.



TEMPLE HEALTH

INSTRUCTIONS AND FORMS

These forms will help you decide how to direct your medical care in the event you are not able to speak for yourself. While it is hard to think about what might happen with your health in the future, these forms give you choices that you may wish to make.

Please take some time to read this booklet and fill out the forms. Be sure to ask questions and talk about these choices with your family, close friends, and doctors. You will keep the original and we will keep a copy in your medical record.

DEFINITIONS

1. LIVING WILL

This form lets you talk about your wishes for your healthcare in the event you can no longer do so. It only goes into effect if you have a terminal illness (near death), are permanently unconscious (in a coma) or in a persistent vegetative state. The law says your doctor must follow your wishes.

2. DURABLE POWER OF ATTORNEY

The Durable Power of Attorney for Healthcare lets you choose a person who will make medical choices for you if you are not able to do so. The person you chose is called your Surrogate. You may also choose a second Surrogate if the first person you choose cannot be reached.

3. INSTRUCTIONS TO MY SURROGATE (optional)

These directions give you a way to tell your Surrogate about your wishes, so that they may carry them out. These instructions are not legally binding (required by law), but help them get a sense of what you would want when you can no longer speak for yourself. We cannot plan for every change in your health.

LIVING WILL - YOUR WISHES ABOUT HEALTHCARE

I, (Printed Patient's Name)_____ Date of Birth_____
being of sound mind, willfully and voluntarily make this declaration to be followed if I can no longer make decisions for myself.

I direct my doctor and healthcare team to withhold or withdraw life–sustaining treatment that serves only to prolong the process of my dying if I should be in a state of permanent unconsciousness (coma) or terminal illness (near death).

I direct that treatment be limited to efforts to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel strongly about the following forms of treatment:
(Please check any preferences below)

I _____ do **_____ do not** want cardiac resuscitation (CPR).

I _____ do **_____ do not** want to be put on a ventilator (breathing machine).

I _____ do **_____ do not** want tube feeding or any other artificial or invasive form of hydration (water). This includes a feeding tube put into the stomach.

I _____ do **_____ do not** want blood or blood products.

I _____ do **_____ do not** want kidney dialysis.

I _____ do **_____ do not** want blood drawing or getting stuck by needles.

I _____ do **_____ do not** want any form of surgery or invasive diagnostic tests.

I _____ do **_____ do not** want to make an organ donation gift of all or part of my body, with the following limitations, if any: _____
_____

I make this declaration on (Date)_____

Signature (Patient's Name)_____

I state that the declarant knowingly and voluntarily signed this document by writing his/her signature or mark in my presence.

Witness' Signature (Print)_____

_____ _____ _____
(Address) (City) (State) (Zip Code)

Witness' Signature (Print)_____

_____ _____ _____
(Address) (City) (State) (Zip Code)

HEALTHCARE POWER OF ATTORNEY

of (Patient's Name)_____ Date of Birth_____

1. DESIGNATION OF SURROGATE

I understand my right to make my own decisions to accept or refuse health care treatments. If I become unable to make a treatment decision, I appoint as my Surrogate for healthcare decisions:

Surrogate's Name (Print)_____

_____ _____ _____

(Address) (City) (State) (Zip Code)

_____ _____ _____

(Email) (Telephone) (Relationship)

2. SUBSTITUTE OF SURROGATE (optional)

If he/she cannot be reached or is unwilling or unable to make decisions, I appoint the following person as my substitute surrogate:

Surrogate's Name (Print)_____

_____ _____ _____

(Address) (City) (State) (Zip Code)

_____ _____ _____

(Email) (Telephone) (Relationship)

_____ _____ _____

Patient's Signature Witness' Signature Witness' Signature

_____ _____ _____

Date Date Date

We suggest that you make copies for:
• Yourself • Your family • Your surrogate • Your healthcare team

INSTRUCTIONS TO MY SURROGATE (Optional)

MY MOST IMPORTANT VALUES

The most important things to me with respect to my health and healthcare are:
(Check as many as you wish)

_____ **To live as long as I can, even if I am less able or not able to function.**
(You may explain more)

_____

_____

_____ **To keep my dignity.** (You may explain more)

_____

_____

_____ **To have a good quality of life.** (You may explain more)

_____

_____

_____ **To be able to communicate with other people.** (You may explain more)

_____

_____

_____ **To be free from pain.** (You may explain more)

_____

_____

_____ **Other.** (Please explain)

_____

_____

Know your choices, Share your wishes

Keep control, get peace of mind, and make sure your wishes are honored.

Provided by Temple Health

Thank you for completing your Advance Directive!

We hope this helps to point you, your loved ones, and the medical team caring for you in the right direction.

TEMPLE HEALTH

800-Temple-Med (800-836-7536)

TempleHealth.org

facebook.com/templehospital

twitter.com/templehealthmed

youtube.com/templehospital

TEMPLE HEALTH

Temple University Hospital
Lewis Katz School of Medicine at Temple University
Fox Chase Cancer Center
Jeanes Hospital

Temple Health Oaks
Temple Health Center City
Temple Health Ft. Washington
Temple Health Elkins Park

Temple ReadyCare
Temple Physicians
Temple Transport Team

TUH – Episcopal Campus
TUH – Northeastern Campus

TH-950006 (10-17)