ADVANCE HEALTH CARE DIRECTIVE
ANSWERS FOR: ____________________

Powers of Attorney for Health Care

Agents:

Name: ____

Address: ______________________________________

Telephone Number: ____________________________

Name: ____

Address: ______________________________________

Telephone Number: ____________________________

Name: ____

Address: ______________________________________

Telephone Number: ____________________________

Immediately Effective, or Springing

My agent's powers should be effective ☐ immediately, as HBZV recommends
☐ only upon my incapacity

Organ and Tissue Donation

☐ My agent is *not* authorized to make anatomical gifts (gifts of my body parts), upon my death.

ALTERNATIVELY:

☐ I wish to be an organ and tissue donor, upon my death.

☐ I wish to limit my donation as follows:

☐ I give my body to be used for research by a medical hospital, accredited medical school or dental school, or by a university.

Any particular institution? ___________________________

☐ I give any part for transplant or therapy.

☐ I give only the following parts for transplant or therapy:

____

☐ I do not wish to limit the donation of my body or any parts. My agent has full authority to make these decisions, after I die.

Disposition of Remains

☐ I have a pre-need contract with a mortuary or cremation service.

Please provide details: ____

☐ My agent may direct the disposition of my remains.

Autopsy

☐ I am opposed to autopsies and my agent shall not have the power to grant an autopsy except in those circumstances in which they are required by law.

☐ My agent may authorize an autopsy.

Primary Care Physician

☐ I wish to designate my primary care physician as follows:

Name: ____

Address: ____

Telephone Number: _______________________________

☐ I wish to allow my agent to select a primary care physician for me.

Individual Health Care Instructions

Powers of Attorney, Only

I do not want to leave individual health care instructions. Instead, I will discuss with my agents various end-of-life scenarios and my wishes should my agents need to make decisions on my behalf.

If the above is true, check here ☐ and **DO NOT COMPLETE** the rest of the form.

Written Instructions: Option ONE

If you would like to leave individual health care instructions *that would allow your doctors to withhold or withdraw treatment*, please read the following and check the box next to the statement(s) that best describe(s) your wishes. **You may choose more than one box.**

If I am in an irreversible coma or persistent vegetative state,

☐ I do not want efforts made to prolong my life and I do not want life-sustaining treatment to be provided or continued.

☐ At all times, I should be given treatment to alleviate pain or discomfort, even if the treatment hastens my death. I wish to receive any forms of palliative care that may provide me comfort.

☐ The above also would be true if I were terminally ill and the use of life-sustaining procedures would serve only to artificially delay the moment of my death, or if the burdens of treatment would outweigh the expected benefits.

Written Instructions: Option TWO

Option TWO is inconsistent with Option ONE; choose either option, but not both options.

If you would like to leave individual health care instructions *that would prolong or sustain your life*, please read the following and check the box next to the statement that best describes your wishes.

I want to live as long as possible; therefore, I want to receive all medical treatment that will prolong and sustain my life within the limits of generally accepted heath care standards. I want such treatment provided to me regardless of my chances of recovery, my condition, or the cost of such treatment.

EITHER:

☐ The above statement is true, however at all times, I should be given treatment to alleviate pain or discomfort, even if the treatment hastens my death. I wish to receive any forms of palliative care that may provide me comfort.

OR:

☐ The above statement is true and I would not want any treatment that might hasten my death, even if I were in pain.

Written Instructions: In Your Own Words

If you would like to add additional instructions to your health care directive, written in your own words, please provide us with those instructions.