Vermont Advance Directive for Health Care

Prepared by the Vermont Ethics Network

Explanation and Instructions

- You have the right to give instructions about what types of health care you want or do not want.
- You also have the right to name someone else to make health care decisions for you when you are unable to make them yourself.
- You may also have that person's authority begin immediately or upon any chosen circumstance.
- You may do either of these by telling your family or your doctor, but it is generally better for you and your family if you write down your wishes in an Advance Directive.
- You may use this form in its entirety or you may use any part of it. For example, if you simply want to choose an agent in Part One, you may do so and go directly to Part Five to sign this in the presence of appropriate witnesses.
- You are also free to use a different form as long as it is properly signed and witnessed.

Part One of this form lets you name a person as your **"agent"** to make health care decisions for you if you become unable or unwilling to make your own decisions. You may also name co-agents or alternate agents. You should choose as your agent (and alternates) people you trust, who are going to be comfortable making what might be hard decisions on your behalf. They should know you and be guided by your values in making choices for you.

You should notify your agent and alternates that you have named them, and they need to agree to act as your agent if asked to do so. Your agent does not have authority to make decisions for you until you are unable to make your own decisions.

If you do not appoint an agent, and then become unable to make your own decisions, it will be unclear who will make health care decisions for you. In the state of Vermont, this authority does not automatically fall to a specific family member.

Part Two of this form lets you state **Treatment Wishes**. Choices are provided for you to express your wishes about having, not having, or stopping treatment necessary to keep you alive under certain circumstances. Space is also provided for you to write out any additional or specific wishes based on your values, health condition, or beliefs.

Part Three of this form lets you express your wishes about **organ or tissue donation**.

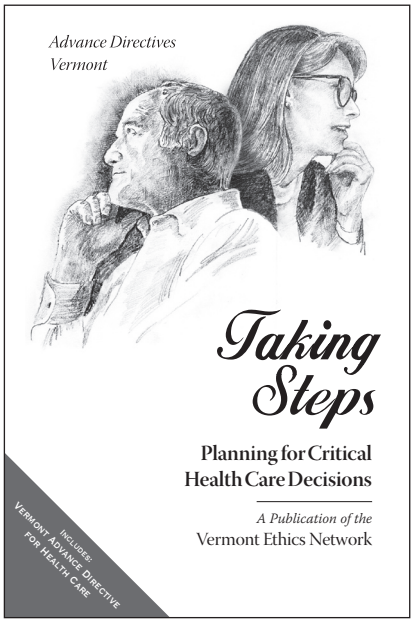
Part Four allows you to express your wishes about **funeral arrangements** or other provisions for your remains after you die.

Part Five of this form is for **signatures**. You must sign and date the form in the presence of two adult witnesses. The **following persons may *not* be witnesses:** your agent and alternate agents; your spouse or partner; parents; siblings; reciprocal beneficiary; children and grandchildren.

You should **give copies of the completed form to your agent and alternate agents**, to your physician, your family and to any health care facility where you reside or at which you are likely to receive care. You are also encouraged to send a copy of your Advance Directive to the **Vermont Advance Directive Registry** with the Registration Agreement Form so that it can be found immediately on a computer by care givers where you are receiving care in a crisis or emergency. You should keep a list of those who have copies in case you revoke or revise the document in the future.

You have the right to revoke all or part of this advance directive for health care or replace this form at any time. If you do revoke it, all old copies should be destroyed. If you make changes and have sent a copy of your original document to the Vermont Advance Directive Registry, be sure to send them a new copy or a notification of change form with information needed to update your Advance Directive there.

You may wish to read the booklet ***Taking Steps*** to help you think about and discuss different choices and situations with your agent or loved ones. Copies of the booklet are available through the Vermont Ethics Network, 64 Main St., Room 25, Montpelier, VT 05602. You may also order it through the VEN website: www.vtethicsnetwork.org. For information about the Vermont Advance Directive Registry, ask for the companion brochure: ***Registering Your Advance Directive*** or visit the Registry website set up by the Vermont Department of Health: **www.healthvermont.gov/vadr**.



VERMONT
DEPARTMENT OF HEALTH

Registry Use Only
Received:
Confirmed:

Vermont Advance Directive Registry

REGISTRATION AGREEMENT

VERMONT DEPARTMENT OF HEALTH SOURCE CODE: 53101301

1. Read the *Registration Policy*, and complete this *Registration Agreement*. Please type or print clearly. Be sure to sign and date the form.
2. Attach either a copy of your advance directive, or optionally, an *Advance Directive Locator* form which indicates only the physical location of your advance directive so that it can be retrieved.
3. Registrations MUST include a completed and signed *Registration Agreement* form, and a copy of your advance directive document.
4. MAIL to: Vermont Advance Directive Registry (VADR)
   523 Westfield Ave., PO Box 2789
   Westfield, NJ 07091-2789
5. OR FAX to: 908- 654-1919

For forms, or additional information visit: http://healthvermont.gov/vadr/ or call 1-800-548-9455

Registrant

Name: First _____ Middle _____ Last _____ Suffix ____

Gender: Male___ Female___ **Date of Birth** (MM/DD/YYYY): _____/_____/_____

Primary Mailing Address: _____ Apt # _____

City/Town: _____ **State**: _____ **Zip**: _____

Phone: Home ( ) _____-_____ Work ( ) _____-_____ Other ( ) _____-_____

Secondary Mailing Address: _____ Apt # _____

City/Town: _____ **State**: _____ **Zip**: _____

Emergency Contacts

Primary: Name _____ Relationship to Registrant: _____

Mailing Address: _____

City/Town: _____ **State**: _____ **Zip**: _____

Phone: Home ( ) _____-_____ Work/Other: ( ) _____-_____

Secondary: Name _____ Relationship to Registrant: _____

Phone: Home ( ) _____-_____ Work/Other: ( ) _____-_____

Does your advance directive make you an organ donor? (Circle one) ***YES*** ☐ ***NO*** ☐

*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**: ____/____/_____

VERMONT ADVANCE DIRECTIVE REGISTRY
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, the registrant must complete and send the *Registration Agreement* form along with a copy of the advance directive to:

   The Vermont Advance Directive Registry
   523 Westfield Ave., PO Box 2789
   Westfield, New Jersey 07091-2789.

   To register the physical location of the advance directive document, rather than the document itself, the registrant may send the *Advance Directive Locator* form instead of a copy of the advance directive. This form is downloadable from the Registry website.

2. Upon receipt of the *Registration Agreement* and attachments, the Registry will scan the advance directive (or *Advance Directive Locator* form), 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.

3. 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.

4. 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.

5. Initial registration as well as subsequent changes and updates to the registration information or the advance directive documents are free of charge.

6. 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.

7. Only the Registry can change the terms of the *Registration Agreement*.

Advance Directive

MY NAME ..... DATE OF BIRTH (DOB) ..... DATE .....

ADDRESS .....

CITY ..... STATE ..... ZIP .....

Part One: Appointment of My Health Care Agent

I appoint .....

ADDRESS .....

PHONE (DAY) ..... (EVENING) .....

CELL PHONE ..... EMAIL .....

as my health care **agent** to make any and all health care decisions for me, *except to the extent that I state otherwise in this document.* (If you appoint co-agents, list above or on a separate sheet of paper.)

If this health care agent is unavailable, unwilling, or unable to do this for me, I appoint

..... to be my **alternate agent.**

ADDRESS: .....

PHONE (DAY) ..... (EVENING) .....

CELL PHONE ..... EMAIL .....

(Use additional sheet to appoint additional agents or alternates.)

Others who can be consulted about medical decisions on my behalf include:

.....

.....

Those who should *NOT* be consulted include:

.....

.....

Your agents should have been notified that you appointed them. They should understand your wishes and they should agree to make health care decisions for you when you are no longer able to, or no longer wish to make them for yourself.

(Optional space below is to identify your doctor or health care provider:)

PRIMARY CARE PHYSICIAN (OR OTHER HEALTH CARE CLINICIAN) .....

ADDRESS ..... PHONE .....

OTHER HEALTH CARE PROFESSIONAL .....

ADDRESS ..... PHONE .....

Name _____ DOB _____ Date _____

Part Two: Treatment Wishes

Please initial the statements below that fit your preference. You may initial more than one choice. *If you choose nothing, your agent, family members, and doctors will assume you want them to decide for you. If you do not state a preference for withholding or withdrawing tube feeding, and you are being treated in a hospital in another state, your agent may not have authority to withhold or withdraw it, without a court order.*

The statements below are applicable at a time when I may be so ill, injured or impaired that I lack the capacity to make my own medical decisions

_____ **A. My choice is to try to Sustain Life.** I want my life to be prolonged as long as possible through any reasonable medical means regardless of my condition or awareness or quality of life. (If this statement sums up your wishes, you may wish to move on to the signature section of Part Five.)

_____ **B. I do not want my life prolonged if** (initial all that apply):

_____ I am so sick that I have only weeks, days, or hours left to live.

_____ I become unconscious or unaware of my surroundings and my doctors agree that I will never regain consciousness.

_____ I become unable to think or act for myself and won't get better.

_____ If it becomes clear to my doctor, my agent, and those caring for me that I am dying, I want comfort care to relieve my pain and other symptoms that are bothering me. I want sufficient **pain medication** even though it may have the unintended effect of hastening my death.

_____ I prefer to die at home if possible and be referred to **Hospice care**.

_____ **C. My Choice is to Limit Treatment in the following ways, even if none of the conditions I've checked in Part B apply:**

1. If my heart stops: (choose one)

❑ I **DO** want CPR done to try to restart my heart.

❑ I **DON'T** want CPR done to try to restart my heart.

CPR means cardio-pulmonary resuscitation, including vigorous compressions of the chest and air forced into the lungs through a facemask.

2. If I am unable to breathe on my own: (choose one)

❑ I **DO** want a breathing machine without any time limit to keep me alive.

❑ I want a breathing machine for a short time to see if I will survive or get better.

❑ I **DON'T** want a breathing machine.

"Breathing machine" refers to a ventilator or respirator, not to portable machines that may support my breathing with oxygen.

Name _____ DOB _____ Date _____

3. If I am unable to swallow enough food or water to stay alive: (choose one)

❑ I **DO** want a feeding tube without any time limit.

❑ I want to have a feeding tube for a short time to see if I will survive or get better.

❑ I **DON'T** want a feeding tube for any length of time.

❑ I want my health care agent to decide about feeding tubes.

4. If I am terminally ill or so ill that I am unlikely to get better: (choose one)

❑ I **DO** want antibiotics or other medication to fight infection.

❑ I **DON'T** want antibiotics or other medication to fight infection.

_____ **D. Other specific instructions or comments are as follows:**

.....

.....

.....

.....

Spiritual and Other Care Concerns

I am of the _____ faith. Below is the contact information (if known).

Church, synagogue, or worship center:

.....

ADDRESS .....

.....

LEADER.....

PHONE .....

Other people to notify if I have a life-threatening illness:

.....

.....

.....

The following items or music or readings would be a comfort to me:

.....

.....

Name _____ DOB _____ Date _____

Part Three: Instructions about Organ and Tissue Donation

I wish to make known my decisions regarding organ and tissue donation and whole body donation so that my instructions will be followed after my death.

I **consent to donate** the following organs and tissues:

____ any needed organs (heart, lung, kidney, liver)

____ any needed tissue (such as cornea, bone, and skin)

I do **not** wish to donate the following organs and tissues:

.....

.....

____ I wish to make **no decision** about organ and tissue donation at this time.

____ I do **not** wish to be an organ and tissue donor.

____ I wish to donate my body to research or educational programs. (Note: you will have to make your own arrangements through a medical school or other program in advance.)

____ If an **autopsy** is suggested for any reason, I consent to have it done.

Part Four: My Wishes for Disposition of My Remains After My Death

I. I have a **pre-need contract** for funeral arrangements with the following funeral service:

NAME .....

ADDRESS .....

PHONE .....

II. My preference for **those who should decide** about my burial or disposition of my remains after I die—I want the following person or persons to decide arrangements after my death:

❑ health care agent ❑ alternate agent ❑ family ❑ Other designee (specify below):

NAME .....

ADDRESS .....

PHONE .....CELL PHONE .....

EMAIL .....

Name _____ DOB _____ Date _____

III. Specific Wishes:

____ I want a funeral followed by burial in a casket.

____ I want to be cremated and my ashes kept or scattered as follows:

.....

.....

.....

____ If it is possible, I would like my remains to be buried at the following location (name of cemetery, city, state, etc.):

.....

.....

.....

Part Five: Signed Declaration of Wishes

I declare that this document reflects my desires regarding my future health care (organ and tissue donation and disposition of my body after death) and that I am signing this Advance Directive of my own free will.

SIGNED ..... DATE .....

The witnesses below confirm the signature of the maker of this document and that it is being signed by that person as a free and voluntary act. Witnesses affirm that Principal appears to understand the nature of the Advance Directive and there is no duress or undue influence to sign. *The following people may **not** sign as witnesses: your agent(s), spouse, reciprocal beneficiary, parents, siblings, children, or grandchildren.*

(Please sign and print)

FIRST WITNESS ..... DATE .....

ADDRESS .....

SECOND WITNESS ..... DATE .....

ADDRESS .....

If the maker signing this document is a current patient or resident in a hospital, nursing home, or residential care home, an additional person (designated hospital explainer, long-term care ombudsman, member of the clergy, Vermont attorney, or person designated by the probate court) needs to confirm below that he or she has explained the nature and effect of the Advance Directive and the patient or resident appears to understand this.

NAME ..... TITLE / POSITION .....

ADDRESS ..... DATE .....

Important!

Please check below the people and locations that will have a copy of this document:

❑ Vermont Advance Directive Registry — Date registered: _____

❑ Health care agent ❑ Alternate health care agent

❑ Family members *(List all who have copies)*:

NAME ....

ADDRESS .....

NAME ....

ADDRESS .....

NAME ....

ADDRESS .....

NAME ....

ADDRESS .....

NAME ....

ADDRESS .....

NAME ....

ADDRESS .....

NAME ....

ADDRESS .....

❑ MD NAME..... ADDRESS.....

❑ Hospital(s) .....

.....

❑ Other individuals or locations:

NAME ....

ADDRESS .....

NAME ....

ADDRESS .....

NAME ....

ADDRESS .....

NAME ....

ADDRESS .....