central peninsula
hospital | heritage place
250 Hospital Place, Soldotna, AK 99669
(907) 714-4404 * www.cpgh.org
232 Rockwell Ave, Soldotna, AK 99669
(907) 262-2545 * www.cpgh.org

ADVANCE HEALTH CARE DIRECTIVES FOR:

(Short Form)

Name: _____

Address: _____

City : _____ State : _____ Zip : _____

Phone number (Home, Work, Cell): _____

Date of Birth: _____ Social Security Number: _____

EXPLANATION OF FORM

This form has been developed for your convenience by Central Peninsula Hospital. However, if you have any questions about the legal effect of the language used in this form, or how this form affects your rights, or the rights of your family, please contact an attorney. This form, and the explanations and instructions within it, are not intended to be, and are not a substitute for legal advice.

You have the right to give instructions about your own health care to the extent allowed by law. **Part 1 of this form lets you give specific instructions for any aspect of your health care.** You can express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive (including artificial nutrition and hydration), as well as the provision of pain relief medication. There is additional space provided for you to write out any other wishes.

Part 2 of this form lets you express an intention to make an anatomical gift following your death.

You also have the right to name someone else to make health care decisions for you. **Part 3 of this form is a durable power of attorney for health care decisions**, which lets you name another individual as an agent to make health care decisions for you: if you do not have the capacity to make your own decisions; or if you want someone else to make those decision for you now, even though you still have the capacity to make those decision. You may name alternate agents if your fist choice is not willing, able, or reasonably available to make decisions for you. This form also allows you to limit the authority of your agent if you choose.

You may complete or modify all or any part of this form. You are free to use a different form if the form complies with the requirement of Alaska Statutes 13.52.

PART 1
INSTRUCTIONS FOR HEALTH CARE

In filling out these Instructions for Health Care, you may strike any wording you
(1) *do not want.*

END-OF- LIFE DECISIONS

Except to the extend prohibited by law, I direct that my health care providers and other involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below *(check only one box):*

[ ] (A) CHOICE TO PROLONG LIFE. I want my life to be prolonged as long as possible with in the limits of generally accepted health care standards.

OR

[ ] (B) CHOICE NOT TO PROLONG LIFE. I want comfort care only and I do not want my life to be prolonged with medical treatment if, in the judgment of my physician, I have (*check all choices below that represent your wishes*):

[ ] A Condition Of Permanent Unconsciousness: a condition that, to a high degree of medical certainty, will last permanently with out improvement; in which, to a high degree of medical certainty, thought, sensation, purposeful action, social interaction, and awareness of myself and the environment are absent; and for which, to a high degree of medical certainty, initiating or continuing life-sustaining procedures for me, in light of my medical outcome, will provide only minimal medical benefit for me; or

[ ] A Terminal Conditions: an incurable or irreversible illness or injury that without the administration of life-sustaining procedures will result in my death in a short period of time, for which there is no reasonable prospect of cure or recovery, that imposes severe pain or otherwise imposes an inhumane burden on me, and for which, in light of my medical condition, initiating or continuing life-sustaining procedures will provide only minimal medical benefit;

[ ] Additional Instructions:

_____

(2) _____

ARTIFICIAL NUTRITION AND HYDRATION.

If (and only if) I am unable to safely take nutrition, fluids, or nutrition and fluids *(check your choices or write your instructions):*

[ ] I wish to receive artificial nutrition and hydration indefinitely.

[ ] I wish to receive artificial nutrition and hydration indefinitely, unless it clearly increases my suffering and is no longer in my best interest.

[ ] I wish to receive artificial nutrition and hydration on a limited trial basis to see if I can improve.

[ ] In accordance with my choices in (1) (B) above, I do not wish to receive artificial nutrition and hydration.

[ ] Other instructions: _____

_____

(3) **RELIEF FROM PAIN**

[ ] I direct that adequate treatment be provided at all times for the sole purpose of the alleviation of pain or discomfort: **OR**

[ ] I give these instructions:

_____

_____

_____

(4) **IF I AM PREGNANT AND BECOME UNCONSCIOUS,** I direct that:

_____

_____

_____

(5) **OTHER WISHES.**

If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.

I direct that _____

_____

_____

_____

Conditions or limitations: _____

_____

_____

_____

(*Add additional sheets if needed)*

(6) **OPTIONAL PROVISIONS.**

If you wish, you may make other health care decisions in advance, relating to Mental Health Treatment, Designation of Primary Physician, Appointment or disqualification of Surrogate, and Do Not Resuscitate orders. If you wish to make these kinds of health care decisions, please contact your attorney or health care provider for more information.

PART 2
ANATOMICAL GIFT AT DEATH

(7) **<u>UPON MY DEATH</u>** *(mark applicable box):*

[ ] (A) I give any needed organs, tissues, or other body parts,

OR

[ ] (B) I give the following organs, tissues, or other body parts only:

_____

_____

_____

My gift under (A) or (B) above is for the following purpose *(mark any of the following you want):*

[ ] transplant;

[ ] therapy;

[ ] research;

[ ] education;

[ ] other *(describe):*

_____

_____

_____

[ ] (C) I refuse to make an anatomical gift.

FOR MORE INFORMATION;
Call 1-800-719-LIFE
(1-800-719-5433)
Internet:
<u>www.lifealaska.org</u>

PART 3
DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

(8) **DESIGNATION OF AGENT**

I designate the following individual as my agent to make health care decisions for me:

Name _____

Address _____

City _____ State _____ Zip _____

Phone (Home, Work, Cell) _____

ALTERNATE 1: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

Name _____

Address _____

City _____ State _____ Zip _____

Phone (Home, Work, Cell) _____

ALTERNATE 2: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

Name _____

Address _____

City _____ State _____ Zip _____

Phone (Home, Work, Cell) _____

(9) **AGENT'S AUTHORITY**

My agent is authorized and directed to follow my instructions in Parts 1 and 2 above, and my other wishes to the extent known to the agent in making all health care decisions for me. **In the event of a conflict between my instructions in Parts 1 and 2 above and my agent's authority or instructions, my instructions in Parts 1 and 2 control, unless these instructions are later revoked.** If Parts, 1 and 2 are not filled in, or my health care instructions or wishes regarding anatomical gifts are not known, then my agent is authorized to make these decisions in accordance **with my best interest**, including decisions to provide, withhold, or withdraw artificial hydration and nutrition and other forms of health care to keep me alive, except as I state here:

_____

_____

_____

(Add additional sheets if needed)

(10) **WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE.**

[ ] My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions.

OR

[ ] My agent's authority to make health care decisions for me takes effect immediately after I sign this form; provided, however, that my instructions in parts 1 and 2, above, control over the authority of my agent, unless these instructions are later revoked.

(11) **AGENT'S OBLIGATION**

My agent shall make health care decisions for me in accordance with; any instructions I give in Parts 1 and 2 of this form; this durable power of attorney for health care; and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent. In the event of a conflict between my instructions in Parts 1 and 2 above and my agent's authority or instructions, my instructions in Parts 1 and 2 control, unless these instructions are later revoked.

(12) **NOMINATION OF GUARDIAN**

If a guardian of my person needs to be appointed for me by a court *(choose one)*:

[ ] I nominate the agent designated in Part 3 (8) of this form, above. If that agent is not willing, able, or reasonably available to act as guardian, then I nominate the alternate agents whom I have named under Part 3(8) above, in the order designated.

OR

[ ] I nominate the following person to be my guardian:

Name _____

Address _____

PART 4 EXECUTION OF FORM

(13) **EFFECT OF COPY.** A copy of this form has the same effect as the original.

(14) **SIGNATURE.** In the presence of the notary public, sign and date the form here:

Signature _____ Date _____

Print Name: _____

STATE OF ALASKA)
THIRD JUDICIAL DISTRICT)

THE FOREGOING INSTRUMENT was acknowledged before me this day of_____, 20__by

_____
Notary Public for the State of Alaska
My Commission Expires:_____