Advanced Directives

As required by Pennsylvania Law and COBRA Patient Self-Determination Act of 1990, information is made available to our patients concerning their rights to execute directives.

Information is provided concerning the following directives:

- Living Wills
- Health Care Proxy
- Durable Power of Attorney

It is the policy of **PHYSICIANS SURGICAL CENTER** to treat all patients equally in the provision of medical care without regard as to whether or not the patient has executed an advance directive. It is our intent to sustain life with extraordinary efforts should the need arise.

This brochure is intended solely for information as required by law. Patients should consult with their family attorney, physician or other advisors before making any decision. The patient is under no obligation to obtain any of the above documents.

Advance Health Care Directive Kit

Including:

- Advance Health Care Directive Form
    - Power of Attorney for Health Care (PAHC)
    - Instructions for Health Care
    - Donations of Organs at Death (Optional)
    - Primary Physician Designation (Optional)
- Advance Health Care Directive Distribution List
- Wallet Size Advance Health Care Directive Card

ADVANCE HEALTH CARE DIRECTIVE

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes about organ donation and to specify your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a Power of Attorney for Health Care. Part I lets you name another individual as an agent to make health care decisions for you if you become unable to make your own decisions or if you want someone else to make those decisions for you now even though you are still able. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to you or is a co-worker).

Unless you limit the authority of your agent in this form, your agent may make all health care decisions for you. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

(b) Select or discharge health care providers and institutions.

(c) Approve or disapprove diagnostic tests, surgical procedures, and programs of medication.

(d) Direct the provision, withholding, or withdrawal or artificial nutrition and hydration and all other forms of health care, including cardiopulmonary resuscitation.

(e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent. Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

Part 5 – After completing this form, sign and date the form at the end. The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, to any health care agents you have named, and to anyone you think is likely to be contacted in the event of an emergency. You should talk to the person you have named as an agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this Advance Health Care Directive or replace this form at any time.

PART I
POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

____
(name of individual you choose as an agent)

____
(address) (city) (state) (zip code)

____
(home phone) (work phone) (cell phone)

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

____
(name of individual you choose as first alternate agent)

____
(address) (city) (state) (zip code)

____
(home phone) (work phone) (cell phone)

OPTIONAL: If I revoke the authority of my agent and the first alternate agent or if neither is willing, able, or reasonably available to make health care decisions for me, I designate as my second alternate agent:

____
(name of individual you choose as a second alternative agent)

____
(address) (city) (state) (zip code)

____
(home phone) (work phone) (cell phone)

(1.2) **AGENT'S AUTHORITY**: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

____

____

____

____

PART I (continued)

(1.3) **WHEN AN 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 unless I mark the following box. If I mark this box ⁽, my agent's authority to make health care decisions for me takes effect immediately.

(1.4) **AGENT'S OBLIGATION:** My agent shall make health care decisions for me in accordance with this Power of Attorney for Health Care, any instructions I give in Park 2 of this form, 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.

(1.5) **AGENT'S POST-DEATH AUTHORITY**: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

____

____

____

____

(add additional sheets if needed)

(1.6) **NOMINATION OF CONSERVATOR**: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form to be appointed my conservator. If the agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

If you do not wish to have your designated agent be appointed your conservator, strike out this entire section. (1.6 Nomination of Conservator)

PART 2

INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) **END-OF-LIFE DECISIONS**: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ (a) Choice Not to Prolong Life
I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

☐ (b) Choice to Prolong Life
I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) **RELIEF FROM PAIN**: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

____

____

____

____

(add additional sheets if needed)

(2.3) **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:

____

____

____

____

____

____

____

____

(add additional sheets if needed)

PART 3

DONATION OF ORGANS AT DEATH
(OPTIONAL)

Upon my death (mark applicable box):

☐ (a) I give any needed organs, tissues, or parts, OR

☐ (b) I give the following organs, tissues, or parts only.

____

(c) My gift is for the following purposes (strike any of the following you do not want):

1. Transplant
2. Therapy
3. Research
4. Education

PART 4

PRIMARY PHYSICIAN
(OPTIONAL)

I designate the following physician as my primary physician:

____
(name of physician)

____
(address) (city) (state) (zip code)

____
(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician.

____
(name of physician)

____
(address) (city) (state) (zip code)

____
(phone)

PRIOR DIRECTIVES, REVOKED: I revoke any prior Power of Attorney for Health Care or Natural Death Act Declaration.

You may revoke any part or all of this Advance Health Care Directive at any time. To revoke the appointment of an agent, you must inform your treating health care provider in person or in writing. Completing a new Advance Health Care Directive automatically revokes all prior directives. If you do revoke a prior directive, be sure to inform everyone who has a copy of the old directive and provide them with a copy of the new one.

EFFECT OF COPY: A copy of this form has the same effect as the original.

PART 5 – SIGNATURE

SIGNATURE: Sign and date the form here:

(date)	(sign your name)
(address)	(print your name)
(city) (state)	

STATEMENT OF WITNESSES: Two witnesses are required. I declare under penalty of perjury under the laws of NAME OF YOUR STATE (1) that the individual who signed or acknowledged this Advance Health Care Directive is personally known to me, or that the individual's identity was proven to me by convincing evidence, (2) that the individual signed or acknowledged this Advance Directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this Advance Directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First witness	Second Witness
(print name)	(print name)
(address)	(address)
(city) (state)	(city) (state)
(signature of witness)	(signature of witness)
(date)	(date)

ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of NAME OF YOUR STATE that I am not related to the individual executing this Advance Health Care Directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

(signature of witness)	(signature of witness)

PART 5 (continued)

SPECIAL WITNESS REQUIREMENT (For Skilled Nursing Patients Only)

The following statement is required only if you are a patient in a skilled nursing facility—a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

__________________________ (date)

__________________________ (sign your name)

__________________________ (address)

__________________________ (print your name)

__________________________ (city) (state)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

You may use acknowledgment before a notary public instead of the statement of winesses.

State of (NAME OF YOUR STATE) } SS.

County of ____________________

On this ________ day of ________________ , in the year ________ , before me

____________________ (Name & Title of Officer) personally appeared ____________________ (Name of Signer)

personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is submitted to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud or undue influence.

Notary Seal

____________________ (Signature of Notary)

PEOPLE AND PLACES THAT HAVE A COPY OF MY ADVANCE HEALTH CARE DIRECTIVE

After you have completed your Advance Health Care Directive Form, it is important to give copies of the form to several key people or places. The people you have named as your agent and any alternate agents, your doctor(s) and any family member or friend who is likely to be contacted if there were a medical emergency should all receive a copy. You should also keep copies on hand to take with you to the hospital, nursing home or any other medical facility.

You can use the area below to keep a list of every person or institution that has a copy of your Advance Health Care Directive. This is especially important if you decide to change your directive in any way, because you will need to send everyone on the list an updated version of the form.

Date Advance Health Care Directive Completed: ______________________

Name: ______________________

Address: ______________________

Phone: (_____) ______________________

Fax: (_____) ______________________

Name: ______________________

Address: ______________________

Phone: (_____) ______________________

Fax: (_____) ______________________

Name: ______________________

Address: ______________________

Phone: (_____) ______________________

Fax: (_____) ______________________

Name: ______________________

Address: ______________________

Phone: (_____) ______________________

Fax: (_____) ______________________

Name: ______________________

Address: ______________________

Phone: (_____) ______________________

Fax: (_____) ______________________

Name: ______________________

Address: ______________________

Phone: (_____) ______________________

Fax: (_____) ______________________

Name: ______________________

Address: ______________________

Phone: (_____) ______________________

Fax: (_____) ______________________

Name: ______________________

Address: ______________________

Phone: (_____) ______________________

Fax: (_____) ______________________

Advance Health Care Directive Wallet Card

These wallet cards are provided for the purpose of alerting medical personnel that you have an Advance Health Care Directive in the event that you experience a medical emergency and are unable to talk. You should complete the cards by writing the name and phone number of the agent you have named to speak for you in the space provided. You may also list the name(s) and number(s) of either alternate agents or others who have a copy of your directive. Carry one copy with you at all times and you may give the other to someone who would be likely to be contacted in the case of emergency.

Instructions:

1. Print your name in the space provided.

2. Print the name and phone number of the person(s) you have named as your health care agent(s) in the space provided. If the person has more than two phone numbers, list those where the person is most likely to be reached.

3. Print the name(s) and phone number(s) of any alternate agents or someone who has a copy of your Advance Health Care Directive in the space provided. If you have not named an agent in your directive, be sure to list people who have a copy of your directive on the card. If more than 3 people have a copy of your directive, list those that could be most easily reached in the event of an emergency.

4. Cut out the card(s), fold in half, print side showing, and place it in a conspicuous place in your wallet, billfold or purse. Be sure to update the information as necessary.

IMPORTANT NOTICE TO MEDICAL PERSONNEL

I, ______________________________
(name)

have executed an Advance Health Care Directive. If I am unable to make my own health care decisions, my designated agent has the legal authority to make those decisions on my behalf, including decisions concerning life-sustaining treatment.

Agent's name: ______________________

Phone: (   ) ______________________

Phone: (   ) ______________________

------------------------------fold here------------------------------------

Alt. Agent/Holder(s) of Advance Health Care Directive

Name:______________________

Phone: (   ) ______________________

Phone: (   ) ______________________

Name: (   ) ______________________

Phone: (   ) ______________________

Phone: (   ) ______________________

IMPORTANT NOTICE TO MEDICAL PERSONNEL

I, ______________________________
(name)

have executed an Advance Health Care Directive. If I am unable to make my own health care decisions, my designated agent has the legal authority to make those decisions on my behalf, including decisions concerning life-sustaining treatment.

Agent's name: ______________________

Phone: (   ) ______________________

Phone: (   ) ______________________

------------------------------fold here------------------------------------

Alt. Agent/Holder(s) of Advance Health Care Directive

Name:______________________

Phone: (   ) ______________________

Phone: (   ) ______________________

Name: (   ) ______________________

Phone: (   ) ______________________

Phone: (   ) ______________________