Life Planning Advance Directive

The Patient's Right to Decide

ULTIMATE HEALTH PLANS
Good health is where you live.

Advance Directives and Forms

What is a Living Will

A living will is a legal document that outlines medical treatments you would or would not want to be used to keep you alive. This document can address many end-of-life decisions and preferences that can include:

- Mechanical ventilation: Consider if, when, and how long you would want to be placed on a mechanical ventilator to breathe.
- Tube feeding: Decide if you want to have a tube placed in the stomach to feed you in the event you cannot feed yourself.
- Dialysis: Consider if you want a treatment to remove waste from your blood and manage fluid levels if your kidneys no longer function.
- Palliative Care: Decide on measures you will want to manage pain, address hydration, and remain comfortable at home.

An Anatomical Donation

An anatomical donation directive is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of health care workers. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form or expressing your wish in a living will.

Do Not Resuscitate (DNRO) Order

A Do Not Resuscitate Order is a document that will inform medical personnel that you do not want CPR or other life-sustaining measures to be attempted in the event you stop breathing or your heart stops beating. Medical staff can include emergency staff (911), a person's medical team, and/or hospital or nursing facility staff.

This form must be completed by both the competent person, their health care surrogate, or health care proxy and their physician. This form should be readily available to all medical personnel in the event you are unable to provide it. It should be kept in a noticeable, easily accessible place readily available in the event of an emergency. It is recommended to keep this document on a refrigerator door where emergency medical staff will look for it and a copy with your physicians.

This form can be revoked at any time either orally or in writing. It can be revoked by physical destruction, failure to present, or orally expressing contrary intent by you or your health care surrogate.

In the state of FL, this form must be on a **yellow shaded paper.**

Designation of Health Care Surrogate

A Health Care Surrogate document names a person as your representative to make medical decisions for you if you are unable to make them yourself. In Florida it is also known as a medical power of attorney. Consider naming someone you trust who will follow your living will directives to represent you if you can't represent yourself. You may also designate an alternate surrogate.

Frequently Asked Questions

Am I required to have an advance directive under Florida law?

No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your health care or an anatomical donation may be made for you by a court-appointed guardian, your spouse or domestic partner, your adult child, your parent, your adult sibling, an adult relative, or a close friend.

The person making decisions for you may or may not be aware of your wishes. When you make an advance directive and discuss it with the significant people in your life, it will be better assured that your wishes will be carried out the way you want.

Must an attorney prepare the advance directive?

No, the procedures are simple and do not require an attorney, though you may choose to consult one. A living will and health care surrogate requires 2 witness signatures to be valid. At least one of the witnesses cannot be a spouse or blood relative per FL statute XLIV 765.302.

Where can I find advance directive forms?

Florida law provides a sample of each of the following forms: a living will, a health care surrogate, a DNRO, and an anatomical donation. We have included sample forms as well as resources where you can find more information and other types of advance directive forms below .

Can I change my mind after I write an advance directive?

Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed, and dated. However, you can also change an advance directive by oral statement, physical destruction of the advance directive, or by writing a new advance directive.

If your driver's license or state identification card indicates you are an organ donor, but you no longer want this designation, contact the nearest driver's license office to cancel the donor designation and a new license or card will be issued to you.

What if I have filled out an advance directive in another state and need treatment in Florida?

An advance directive completed in another state, as described in that state's law, can be honored in Florida.

What should I do with my advance directive if I choose to have one?

- If you designate a health care surrogate and an alternate surrogate be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.
- Make sure that your health care provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You also may want to give them a copy.
- Set up a file where you can keep a copy of your advance directive (and other important paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.
- Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.

- If you change your advance directive, make sure your health care provider, attorney and the significant persons in your life have the latest copy.
- If you have a Do Not Resuscitate Order, make sure it is easily accessible and visible in the event someone calls 911.

If you have questions about your advance directives you may want to discuss these with your health care provider, attorney, or the significant persons in your life. Also, please feel free to reach out to a UHP representative with more questions about Life Planning Activities at 1-866-967-3430. (TTY 711).

Additional Advance Directive Resources

Florida Department of Health

More information is available on the Florida Department of Health website, www.doh.state.fl.us or www.MyFlorida.com (type DNRO in these website search engines) or call (850) 245-4440.
Advance

Aging with Dignity

www.AgingWithDignity.org
(888) 594-7437
"Five Wishes" provided under Aging with Dignity gives you the opportunity to acquire advance directives.

Tissue Donor Registry

If you would like to learn more on organ and tissue donation, please visit the Joshua Abbott Organ and Tissue Donor Registry at www.DonateLifeFlorida.org where you can become organ, tissue and eye donors online. If you have further questions about organ and tissue donation you may want to talk to your health care provider.

American Association of Retired Persons (AARP)

www.aarp.org
You can find more information on advance directives by typing "advance directives" in their website search engine.

Advance Directive Forms:

Living Will
Anatomical Donation
Do Not Resuscitate Order (DNRO)
Health Care Surrogate Designation

Living Will

Declaration made this_____day of_____, (20___), I,_____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am mentally or physically incapacitated and

_____ (initial) I have a terminal condition, or

_____ (initial) I have an end-stage condition, or

_____ (initial) I am in a persistent vegetative state, and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate, as my surrogate to carry out the provisions of this declaration:

Name: _____

Address: _____

_____

Phone: _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.
Additional Instructions (optional):

_____

_____

_____

(Signed) _____

Witness Signatures:

Witness: _____ Witness: _____

Printed Name: _____ Printed Name: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

At least one witness must not be a husband or wife or a blood relative of the principal.

Definitions for terms on the Living Will form:

"End-stage condition" means an irreversible condition that is caused by injury, disease, or illness which has resulted in progressively severe and permanent deterioration, and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective.

"Persistent vegetative state" means a permanent and irreversible condition of unconsciousness in which there is: The absence of voluntary action or cognitive behavior of any kind and an inability to communicate or interact purposefully with the environment.

"Terminal condition" means a condition caused by injury, disease, or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death.

These definitions come from section 765.101 of the Florida Statues. The Statutes can be found in your local library or online at www.leg.state.fl.us.

Uniform Donor Form

The undersigned hereby makes this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give:

(a) _____any needed organs or parts

(b) _____only the following organs or parts for the purpose of transplantation, therapy, medical research, or education:

_____

_____

_____

(c) _____my body for anatomical study if needed. Limitations or special wishes, if any:

_____

_____

_____

Signed by the donor and the following witnesses in the presence of each other:

Donor's Signature_____Donor's Date of Birth _____

Date Signed_____City and State _____

Witness_____
Street Address _____
City_____State _____

Witness_____
Street Address _____
City_____State _____

You can use this form to indicate your choice to be an organ donor. Or you can designate it on your driver's license or state identification card (at your nearest driver's license office).

State of Florida
DO NOT RESUSCITATE ORDER

(please use ink)

Patient's Full Legal Name:_____ Date: _____
(Print or Type Name)

PATIENT'S STATEMENT

Based upon informed consent, I, the undersigned, hereby direct that CPR be withheld or withdrawn.
(If not signed by patient, check applicable box):

- ☐ Surrogate
- ☐ Court appointed guardian
- ☐ Proxy (both as defined in Chapter 765, F.S.)
- ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

_____
(Applicable Signature) (Print or Type Name)

PHYSICIAN'S STATEMENT

I, the undersigned, a physician licensed pursuant to Chapter 458 or 459, F.S., am the physician of the patient named above. I hereby direct the withholding or withdrawing of cardiopulmonary resuscitation (artificial ventilation, cardiac compression, endotracheal intubation and defibrillation) from the patient in the event of the patient's cardiac or respiratory arrest.

(_ _ _) _ _ _ - _ _ _ _

_____
(Signature of Physician) (Date) Telephone Number (Emergency)

_____
(Print or Type Name) (Physician's Medical License Number)

DH Form 1896, Revised December 2004

PHYSICIAN'S STATEMENT

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(_ _ _) _ _ _ - _ _ _ _

(Signature of Physician) (Date) Telephone Number (Emergency)

(Print or Type Name) (Physician's Medical License Number)

DH Form 1896, Revised December 2004

State of Florida
DO NOT RESUSCITATE ORDER

Patient's Full Legal Name (Print or Type) (Date)

PATIENT'S STATEMENT

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(If not signed by patient, check applicable box):

- ☐ Surrogate
- ☐ Proxy (both as defined in Chapter 765, F.S.)
- ☐ Court appointed guardian
- ☐ Durable power of attorney (pursuant to Chapter 709, F.S.)

(Applicable Signature) (Print or Type Name)

Designation of Health Care Surrogate

I, _____ designate as my health care surrogate under S. 765.202, Florida Statutes:

Name: _____

Address: _____

_____

Phone: _____

If my health care surrogate is not willing, able, or reasonably available to perform his or her duties, I designate as my alternate health care surrogate:

Name: _____

Address: _____

_____

Phone: _____

INSTRUCTIONS FOR HEALTH CARE

I authorize my health care surrogate to: (Initials required in blank spaces below.)

_____ Receive any of my health information, whether oral or recorded in any form or medium, that:

1. Is created or received by a health care provider, health care facility, health plan, public health, employer, life insurer, school or university, or health care clearinghouse; and
2. Relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.

I further authorize my health care surrogate to:

_____ Make all health care decisions for me, which means he or she has the authority to:

3. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
4. Apply on my behalf for private, public, government, or veteran's benefits to defray the cost of health care.
5. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.

_____ 6. Decide to make an anatomical gift pursuant to part V of chapter 765, Florida Statutes.

Specific instructions and restrictions:

_____

_____

_____

While I have decision making capacity, my wishes are controlling and my physician and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation.

To the extent that I am capable of understanding, my health care surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

This health care surrogate designation is not affected by my subsequent incapacity except as provided in Chapter 765, Florida Statutes.

Pursuant to section 765.104, Florida Statutes, I understand that I may, at any time while I retain my capacity, revoke or amend this designation by:

1. Signing a written and dated instrument which expresses my intent to amend or revoke this designation;

2. Physically destroying this designation through my own action or by that of another person in my presence and under my direction;

3. Verbally expressing my intention to amend or revoke this designation; or

4. Signing a new designation that is materially different from this designation.

My health care surrogate's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I initial either or both of the following boxes:

If I initial this box [_____], my health care surrogate's authority to receive my health information takes effect immediately.

If I initial this box [_____], my health care surrogate's authority to make health care decisions for me takes effect immediately. Pursuant to section 765.204(3), Florida Statutes, any instructions of health care decisions I make, either verbally or in writing, while I possess capacity shall supersede any instructions or health care decisions made by my surrogate that are in material conflict with those made by me.

Signatures: Sign and date the form here:

Date: _____ Sign your name: _____

Address: _____ Print your name: _____

City, State: _____

Signatures of Witnesses:

First Witness

Print Name: _____

Address: _____

City, State: _____

Signature: _____

Date: _____

Second Witness

Print Name: _____

Address: _____

City, State: _____

Signature: _____

Date: _____

The card below may be used as a convenient method to inform others of your health care advance directives. Complete the card and cut it out. Place in your wallet or purse. You can also make copies and place another one on your refrigerator, in your car glove compartment, or other easy to find place.

Health Care Advance Directives

I, _____

have created the following Advance Directives:

____Living Will

____Health Care Surrogate Designation

____Anatomical Donation

____Other (specify) _____

FOLD

Contact:

Name _____

Address _____

_____

_____

Phone _____

Signature _____

Date _____

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