# A TIME TO LIVE

HEALTH CARE INSTRUCTIONS FOR MY FAMILY

I have signed a Medical Power of Attorney designating certain individuals (my Surrogates) to make health related decisions on my behalf if I am unable to do so. I understand this Medical Power of Attorney provides broad authority for my Surrogates to act but does not necessarily tell them how I want them to act. These instructions are intended to express my thoughts and feelings to guide my Surrogates in the difficult decisions about my care. Although my Surrogates have been given full authority and discretion to act, I trust they will honor my wishes as provided in these instructions. As to my other family members and friends, I hope they will support my Surrogates in following my instructions on the way I wish to live and be allowed to die.

## I. CONSULTATION WITH FAMILY, FRIENDS AND ADVISORS

My Surrogates have been given the authority to make health care decisions on my behalf without the consent of any of my other family members. Prior to making these decisions:

_____ I DO NOT want my surrogates to consult with my family.

_____ I want my Surrogates to consult with and consider the opinion of the following individuals:

_____

_____

_____

_____

_____ I want my Surrogates to notify and consult with the following Advisors:

Legal Advisor _____

Religious Advisor _____

Medical Advisor _____

Other Thoughts: _____

_____

II. HOSPITAL IN PATIENT CARE

**A. General Care and Instructions**

____ I prefer a private room, if possible, for the privacy of myself and my family.

____ I want my Surrogates to hire a geriatric care nurse for general medical review/guidance.

____ For medical treatment, consult with _____.

____ I prefer to be discharged when appropriate to my home and not a convalescent center. I understand that in-home care nurses may need to be hired for my care.

Other Thoughts: _____

_____

_____

_____

**B. Surgery and/or Medication (Choose One)**

____ I want my Surrogates to take whatever risks may be necessary in authorizing surgery or medication that may cause my death but might allow me to recover to a higher quality of life than that to which I may otherwise be faced.

____ I do not want my Surrogates to authorize high risk surgery or medication that may cause my death even though it might increase my chances for recovery.

____ I do not want my Surrogates to authorize any surgery or medication except that which may be necessary to alleviate my pain or discomfort.

Other Thoughts: _____

_____

_____

III. LONG TERM CARE ISSUES

____ I prefer to stay in my own home, if at all possible, knowing that this may require 24 hour in-home care which is very expensive. If in-home care is used, I ask that my Surrogates place in storage my valuables and other nice personal items that could tempt my caregivers.

____ If I cannot reasonably be maintained in my own home, I wish to live in a smaller adult foster home (small Adult Living Facility) which will be more of a family home setting.

____ If I cannot reasonably be maintained in my own home and my alternative choices are limited, I prefer to live at: _____.

____ If I cannot reasonably be maintained in my own home, I do prefer to remain in my community near my friends and not be relocated outside of the area.

____ If I cannot reasonably be maintained in my own home, I prefer to be relocated closer to my family in: _____.

____ It is not important to me that I remain in my home if I am unable to live independently. I prefer to be moved to: _____.

____ If I am unable to live independently, I prefer the following individuals to help me with my care and I ask that my financial resources be used to financially assist my caregiver(s):

_____

_____

____ If I cannot reasonably be maintained in my own home and my alternative choices are limited to a nursing home, I ask that a companion be provided for such times as may be appropriate to: keep me clean, help me maintain a neat appearance, assist me with eating, read to me and take me for walks or provide other assistance as I may need to maintain my dignity and quality of life as much as possible.

Other Thoughts: _____

_____

_____

_____

_____

IV. END OF LIFE DECISIONS

I understand that one of the most difficult and emotional decisions my Surrogates may have to make is to allow me to die when the time comes. It is important to me that my wishes as expressed below be honored and followed by my Surrogates and family. I want them to support one another at this difficult time rather than working against each other.

By my use of the term "life supporting treatments" I mean that I am being kept alive by a medical device or treatment to help me breathe or be nourished (feeding tube or intravenous feeding), dialysis, major surgeries or any other medical intervention that is keeping me alive.

**A. Close to Death**

If my medical advisors believe I am likely to die within a short period of time and that treatment would do little to prolong my life, I instruct my Surrogates to take whatever action may be necessary to do the following:

____ I want to be provided or to continue life supporting treatments.

____ If there is any chance treatments will help or any doubt of my condition, I want life supporting treatments to be provided, or continued. At such time as my medical advisors believe these treatments are no longer helping, I want all life supporting treatments terminated.

____ I do not want life supporting treatments and if I am receiving them, I want them to be withdrawn or terminated. I want to be allowed to die.

Other Thoughts: _____

_____

_____

_____

_____

_____

_____

_____

### B. Progressively Severe and Permanent Brain Damage

If I am suffering from a condition that is causing progressively severe and permanent brain damage with no reasonable treatment available and as a result, I am no longer aware of my circumstances or surroundings (Having my eyes open does not necessarily mean I am conscious and aware of my circumstances or surroundings if I cannot speak or understand), I instruct my Surrogates to take whatever action may be necessary to do the following:

____ I want to be provided or to continue life supporting treatments.

____ If there is any chance treatments will help or any doubt of my condition, I want life supporting treatments to be provided or continued. At such time as my medical advisors believe these treatments are no longer helping, I want all life supporting treatments terminated.

____ I do not want life supporting treatments and if I am receiving them, I want them to be withdrawn or terminated. I want to be allowed to die.

Other Thoughts: _____

_____

### C. Coma or Persistent Vegetative State

If I am in a coma from which I am not expected to wake up or if I do wake up, I will in all likelihood have suffered severe and permanent brain damage or if I am in a vegetative state which appears to be an irreversible condition leaving me unaware of my circumstances or surroundings or otherwise unable to talk or understand, I instruct my Surrogates to take whatever action may be necessary to do the following:

____ I want to be provided or to continue life supporting treatments.

____ If there is any chance treatments will help or any doubt of my condition, I want life supporting treatments to be provided or continued. At such time as my medical advisors believe these treatments are no longer helping, I want all life supporting treatments terminated.

____ I do not want life supporting treatments and if I am receiving them, I want them to be withdrawn or terminated. I want to be allowed to die.

Other Thoughts: _____

_____

**D. Do Not Resuscitate Order**

I understand that a "Do Not Resuscitate Order" (called a DNR) must be signed by a Doctor as well as myself or my Surrogates. If my medical advisors and Surrogates determine that I am close to death with little or no chance of recovery, I instruct my Surrogates to take whatever action may be necessary to do the following:

____ I DO NOT want my Surrogates to request that my Doctor sign a DNR. I want aggressive treatment provided to me to keep me alive.

____ I WANT my Surrogates to request that my Doctor sign a DNR. If a DNR is signed, I would prefer the following care (choose only one):

____ FULL ACTIVE TREATMENT which means continue my medical care which may be fairly aggressive but if I stop breathing or my heart stops, do not bring me back, allow me to die.

____ COMFORT CARE which means I just want to be kept comfortable and do not want any aggressive measures used to keep me alive. If I stop breathing or my heart stops, do not bring me back, allow me to die.

Other Thoughts: _____

_____

**E. Food and Water; Medication for Pain**

If I am close to death, have severe and permanent brain damage or am in a coma or persistent vegetative state, with little or no chance of recovery, I instruct my Surrogates to take whatever action may be necessary to do the following:

____ I WANT food to be given to me intravenously or by feeding tube if I am no longer able to eat orally.

____ I DO NOT want food to be given to me intravenously or by feeding tube if I am no longer able to eat orally.

____ If I am not able to eat orally and my condition has not improved after _____ weeks/months/years, I want FOOD withdrawn and terminated.

____ I WANT water to be given to me intravenously or by feeding tube if I am no longer able to drink orally.

____ I DO NOT want water to be given to me intravenously or by feeding tube if I am no longer able to drink orally. I want my mouth and face kept moist to prevent them from drying out.

____ If I am not able to drink orally and my condition has not improved after _____ weeks/months/years, I want WATER withdrawn and terminated.

____ I want to be given medication to me to keep me comfortable and without pain.

____ I want to be given LIMITED medication to keep me comfortable and to assist with pain but not to extent that it causes me to become totally unresponsive. I want to be able to communicate with my family if at all possible as I near death.

Other Thoughts: _____

_____

_____

## V. DONATION OF MY BODY FOR MEDICAL RESEARCH

After your death, your body can be donated for medical research. Bodies are accepted unless a person has died from a crushing injury, sepsis or highly communicable disease or it has been autopsied. Your estate will be responsible for the cost of transporting your body to the College (Univ. Of Miami or Univ. of Fla.). After research is completed (up to 2 years), your remains will be cremated and your ashes either returned to your family or spread over the waters of the Gulf of Mexico. Arrangements can be made in advance by contacting the Anatomical Board at 1-800-628-2594.

____ I want my body donated for medical research.
____ Arrangements have been made in advance by me.
____ Arrangements have not been made, I would like my Surrogates to arrange for it.
____ I want my ashes disposed of by the College
____ I want my ashes returned to my family for disposition as per my instructions.
____ I do not want my body donated or used for medical research.

Other Thoughts: _____

_____

_____

_____

VI. ORGAN AND TISSUE DONATION

Organ and tissue donation is available for all individuals regardless of age (under 18 years requires parental consent). Age is not a factor but physical condition is important. Medical suitability is determined at the time of death. Donation does not disfigure the body and does not interfere with having an open casket service. It does though disqualify your body from being used in medical research. There is no cost to your Estate for donation. You can get further information as well as register for organ donation by contacting DONATE LIFE FLORIDA at www.donatelifeflorida.org or by calling 1-877-357-4273. Your decision to donate can also be indicated on your driver's license.

____ I want my organs and tissue made available for donation, if suitable.
____ I have registered with the Florida Organ & Tissue Donor Program.
____ I have not registered but I would like my Surrogates to arrange for it.
____ I do not want to donate my organs or tissue.

Other Thoughts: _____

_____

_____

_____

_____

_____ _____
Dated NAME:

_____ _____
Witness: Witness: