Advance Care Planning

Working Together to Honor Your Wishes

Bay Area Hospital

NBMC North Bend Medical Center

AdvancedHealth

Bay Clinic, LLP Physicians and Surgeons

Waterfall Community Health Center

Completing Your Advance Directive

Share Your Wishes

At Bay Area Hospital, we strive to provide the best care possible. To meet this goal, it is important for us to know the level of care you desire and have a way to honor your wishes. One way to ensure that we do just that is by completing an Advance Directive. An Advance Directive is a document that helps communicate your health-care wishes when you are not able to express them yourself. We encourage everyone, regardless of their health status or age, to have an Advance Directive. A copy of your Advance Directive should be in our health record because an unexpected injury or illness could happen to anyone at any time.

Advance Care: Planning Together

Goals of Advance Care Planning

Advance care planning has two goals. One is to identify the kind of healthcare you want to receive, if you become unable to communicate your choices. The other goal is to name someone you trust to make healthcare decisions for you, in the event that you cannot do so yourself.

The Advance Directive, a State of Oregon legal document, communicates this information to your loved ones and to your healthcare providers. It is never too early to complete an Advance Directive.

If you have any questions about this material, please ask your care providers.

After completing this packet, please take a copy to your Primary Care Provider and Bay Area Hospital.

Advance Directive Information

Please note: You do not have to fill out this form.

PART A: Important Information About This Advance Directive

This is an important legal document. It can control critical decisions about your healthcare. Before signing, consider these important facts:

Facts About PART B: Appointing a Healthcare Representative

You have the right to name a person to direct your healthcare when you cannot do so. This person is called your "healthcare representative." You can do this by using PART B of this form. Your representative must accept on PART E of this form.

In this document, you can write any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts About PART C: Giving Healthcare Instruction

You also have the right to give instructions for healthcare providers to follow if you become unable to direct your care. You can do this by using PART C of this form.

Facts About Completing This Form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this directive, it will not expire. If you have set an expiration date, and you become unable to direct your healthcare before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your healthcare provider of the revocation.

Despite this document, you have the right to decide your own healthcare as long as you are able to do so.

If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes or add words that better express your wishes. Witnesses must sign PART D.

Advance Directive Form

Print your name, birthdate, and address here:

_____ _____

Name *Address Line 1*

_____ _____

Birthdate *Address Line 2*

Unless revoked or suspended, this advance directive will continue for: ***(Initial one)***

_____ My entire life _____ Other period (_____ years)

PART B: Appointment of Healthcare Representative

I appoint _____ as my healthcare representative.

My representative's address is _____

and telephone number is _____.

I appoint _____ my alternate healthcare representative.

My alternate's address is _____

and telephone number is _____ .

I authorize my representative (or alternate) to direct my healthcare when I can't do so.

_____ _____

Signature *Date*

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator, or employee of your healthcare facility, unless that person is related to you by blood, marriage, or adoption, or that person was appointed before your admission into the healthcare facility.

B-1: Limits ***(Initial if this applies)***

_____ I have executed a Healthcare Instruction or Directive to Physicians. My representative is to honor it.

Special Conditions or Instructions: _____

_____

_____

_____

B-2: Life Support ***(Initial if this applies)***

"Life support" refers to any medical means for maintaining life, including procedures, devices, and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

_____ My representative MAY decide about life support for me.
(If you don't initial this space, then your representative MAY NOT decide about life support.)

B-3: Tube Feeding ***(Initial if this applies)***

One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

_____ My representative MAY decide about tube feeding for me.
(If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

Sign here to appoint a healthcare representative:

_____ _____
Signature of person making appointment *Date*

PART C: Healthcare Instructions

In filling out these instructions, keep the following in mind:

- The term "as my physician recommends" means that you want your physician to try life support if your physician believes it could be helpful and then discontinue it if it is not helping your health condition or symptoms.
- "Life support" and "tube feeding" are defined in PART B above.
- If you refuse tube feeding, you should understand that malnutrition, dehydration, and death will probably result.
- You will get care for your comfort and cleanliness, no matter what choices you make.
- You may either give specific instruction by filling out items C-1 to C-4 below, or you may use the general instruction provided by item C-5.

Here are my desires about my healthcare if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

C-1: Close to Death ***(Initial one in each column)***

If I am close to death and life support would only postpone the moment of my death:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

_____ I want NO life support.

C-2: Permanently Unconscious ***(Initial one in each column)***

If I am unconscious and it is very unlikely that I will ever become conscious again:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

_____ I want NO life support.

C-3: Advanced Progressive Illness *(Initial one in each column)*

If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

_____ I want NO life support.

C-4: Extraordinary Suffering *(Initial one in each column)*

If life support would not help my medical condition and would make me suffer permanent and severe pain:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

_____ I want NO life support.

C-5: General Instruction *(Initial if this applies)*

_____ I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in items C-1 to C-4 above.

C-6: Additional Conditions or Instructions *(Insert description of what you want done)*

_____

_____

_____

_____

C-7: Other Documents *(Initial one)*

A "healthcare power of attorney" is any document you may have signed to appoint a representative to make healthcare decisions for you.

_____ I have previously signed a healthcare power of attorney. I want it to remain in effect unless I appointed a healthcare representative after signing the healthcare power of attorney.

_____ I have a healthcare power of attorney, and I REVOKE IT.

_____ I DO NOT have a healthcare power of attorney.

Sign here to authorize your healthcare instructions:

_____ _____

Signature *Date*

PART D: Declaration of Witnesses

We declare that the person signing this advance directive:

a. Is personally known to us or has provided proof of identity;

b. Signed or acknowledged that person's signature on this advance directive in our presence;

c. Appears to be of sound mind and not under duress, fraud, or undue influence;

d. Has not appointed either of us as healthcare representative or alternate representative; and

e. Is not a patient for whom either of us is an attending physician.

Witnessed by:

_____ _____

Signature of Witness/Date *Printed Name of Witness*

_____ _____

Signature of Witness/Date *Printed Name of Witness*

NOTE: One witness must not be a relative (by blood, marriage, or adoption) of the person signing the advance directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate, or be employed at the healthcare facility where the person is a patient or resident.

PART E: Acceptance By Healthcare Representative

I accept this appointment and agree to serve as healthcare representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document allows me to decide about the person's healthcare only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current healthcare provider if known to me.

Healthcare Representative:

_____ _____

Signature of Witness/Date *Printed Name of Witness*

_____ _____

Signature of Witness/Date *Printed Name of Witness*

Bay Area Hospital

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