

UTAH ADVANCE HEALTH CARE DIRECTIVE

You can use this form if you wish to name someone to make health care decisions for you in case you cannot make decisions for yourself. This is called giving the person a power of attorney for health care. The person you choose is called your Agent. Your Agent can only make decisions for you if you are unable to make them yourself.

You can also use this form to state your wishes, preferences, and goals for health care, and to say if you want to be an organ donor after you die. This information can be helpful to your Agent when making decisions for you about your care when you are unable to make them yourself.

Some of the questions on this form concern treatment or situations that you may not have thought about very much. You may need to take time to consider your answers and/or talk to your care team for clarification or more information. If your preferences change at any time after filling out this form, you may fill out a new form to replace the old form.

SECTION ONE

YOUR NAME AND DATE OF BIRTH

Print Your Full Name: _____ Date of Birth: _____

YOUR HEALTH CARE AGENT

This part lets you name someone else to make health care decisions for you. This person will be your Agent and will only make decisions for you when you are unable to make them for yourself. It also allows you to say what limits you want on your Agent's decision-making power. You may leave any item blank.

1. NAMING AN AGENT

I want the following person to be my Agent to make health care decisions for me if I cannot make decisions for myself (list Agent Name, Relationship, & Contact Information, if known):

2. NAMING AN ALTERNATE AGENT

I want the following person to be my Alternate Agent to make health care decisions for me if I cannot and my Agent is not able or available to make them for me (list Alternate Agent Name, Relationship & Contact Information, if known):

3. FLEXIBILITY FOR MY AGENT

Mark or initial below if you want your Agent to have flexibility in following the instructions in this form. If you do not, your Agent must follow your instructions even if your Agent thinks something else would be better for you.

(___) I give my Agent permission to be flexible in applying these instructions if my Agent thinks it would be in my best interest based on what my Agent knows about me.

4. LIMITING MY AGENT'S AUTHORITY

I give my Agent the power to make all health care decisions for me if I cannot make those decisions for myself, **except** what I have written below: (If you do not add a limitation here, your Agent will be able to make all health-care decisions as outlined in this document and that an Agent is permitted to make under state law.)

SIGNATURES

1. YOUR SIGNATURE

Sign Your Name: _____ Today's Date: _____

Print Your Name: _____ City & State: _____

2. SIGNATURE OF A WITNESS

You need a witness if you are using this form to name an Agent. The witness must be an adult and cannot be the person you are naming as Agent, the Agent's spouse, or someone the Agent lives with as a partner. If you are living or receiving care in a nursing home or assisted living facility, the witness cannot be an owner, operator, employee, or contractor of the nursing home or assisted living facility.

TO THE WITNESS: Only sign if you believe the person signing above is doing so voluntarily.

Signature of Witness: _____ Today's Date: _____

Print Witness Name: _____ City & State: _____

SECTION TWO

HEALTH CARE INSTRUCTIONS

The remaining pages of this form let you state your priorities for health care and state what types of health care you do and do not want when your care may require life-sustaining treatment (for example, a breathing machine or feeding tube) or care that may affect how long you will live. You may wish to talk to your health care providers about these options for clarification or more information. This information in **SECTION TWO** can help your Agent make decisions for you if you cannot. You may complete this section now or at a later date.

You may mark or initial each choice. You may leave any choice blank.

Treatment. Medical treatment needed to keep my body alive should:

Always be given to me. (If you mark or initial this choice, you should not mark or initial any other choices in this "Treatment" section.)

OR

CHOOSE ANY APPLICABLE OPTIONS:

Be given to me unless I have a condition that is not curable and is expected to cause my death soon, even if treated.

Be given to me unless I am unconscious and I am not expected to be conscious again.

Be given to me unless I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.

Other (write what you want or do not want):

Food and Liquids. If I cannot swallow and staying alive requires me to get food or liquids through a tube or other means for the rest of my life, then food or liquids should:

Always be given to me. (If you mark or initial this choice, you should not mark or initial any other choices in this "Food and Liquids" section.)

OR

CHOOSE ANY APPLICABLE OPTIONS:

Be given to me unless I have a condition that is not curable and is expected to cause me to die soon, even if treated.

Be given to me unless I am unconscious and am not expected to be conscious again.

Be given to me unless I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.

Other (write what you want or do not want):

ADDITIONAL HEALTH CARE INSTRUCTIONS/PREFERENCES

You can use the following sections to indicate what is important to you, and what is not important to you. This information can help your Agent make decisions for you if you cannot.

You may mark or initial each choice. You may leave any choice blank.

1. MY PRIORITIES

Staying alive as long as possible even if I have substantial **physical** limitations is:

- Very important
- Somewhat important
- Not important

Staying alive as long as possible even if I have substantial **mental** limitations is:

- Very important
- Somewhat important
- Not important

Being free from significant pain is:

- Very important
- Somewhat important
- Not important

Being independent is:

- Very important
- Somewhat important
- Not important

Having my Agent talk with my family before making decisions about my care is:

- Very important
- Somewhat important
- Not important

Having my Agent talk with my friends before making decisions about my care is:

- Very important
- Somewhat important
- Not important

2. OTHER INSTRUCTIONS

You can write in this section more information about your goals, values, and preferences for treatment, including care you want or do not want. You can also use this section to name anyone who you do **not** want to make decisions for you under any conditions:

OPTIONAL SPECIAL POWERS AND GUIDANCE

This part lets you give your Agent additional powers and allows you to provide more guidance about your wishes.

You may mark or initial each choice. You may leave any choice blank.

1. OPTIONAL SPECIAL POWERS

My Agent has the power to do the following things ONLY if I have marked or initialed them below:

Give consent for my admission to a health care facility for mental health treatment, on a voluntary basis, for no more than ___ days (write in the number of days you want). If I do not mark or initial this choice, my Agent MAY NOT admit me as a voluntary patient to this type of facility. (Note: a person can later object to admission to a health care facility for mental health treatment, even if they lack capacity.)

Give consent for my admission to a nursing home that meets my health needs, even if my stay is for more than 100 days.

2. ACCESS TO MY HEALTH INFORMATION

My Agent may obtain, review, and share information about my health needs and health care if I am not able to make decisions for myself. If I mark or initial below, my Agent may also do that **at any time** my Agent thinks it will help me.

I give my Agent permission to obtain, examine, and share information about my health needs and health care whenever my Agent thinks it will help me.

3. NOMINATION OF LEGAL GUARDIAN

A guardian is a person appointed by a court to make decisions for someone who cannot make decisions. You can say who you would want as your legal guardian if you needed one. Filling this out does NOT mean you want or need a guardian.

If a court appoints a guardian to make personal decisions for me, I want the court to choose:

My Agent named in this form. If my Agent cannot be a guardian, I want the Alternate Agent named in this form.

Other (Name, Relationship & Contact Information, if known):

ORGAN DONATION

This part lets you donate your organs after you die. You may leave any item blank.

1. DONATION

Mark or initial **ONLY ONE** choice:

I want to donate my organs, tissues, and other body parts after I die, even if it requires maintaining treatments that conflict with other instructions I have put in this form, EXCEPT those I list below (list any body parts you do NOT want to donate):

I do **not** want my organs, tissues, or body parts donated to anyone for any reason. (If you mark or initial this choice, you should skip the Purpose of Donation section below.)

2. PURPOSE OF DONATION

You may mark or initial all that apply. If you do not mark or initial any of the purposes below, your donation may be used for all of them.

Organs, tissues, or body parts that I donate may be used for:

Transplant Research Therapy Education All of these

YOUR SIGNATURE

Sign Your Name: _____ Today's Date: _____

Print Your Name: _____ City & State: _____

INFORMATION FOR AGENTS

- 1. If this form names you as an Agent, you can make decisions about health care for the person **only** when the person is unable to make their own decisions. If the person regains the ability to make health care decisions, you may no longer make decisions for them. If you are unable or unwilling to act as an Agent, the Alternate Agent named on this form will make decisions, or an alternative decision-maker will be found according to state law.*
- 2. In making decisions for the person, follow any instructions the person gave, including any in this form.*
- 3. If you do not know what the person would want, make the decision that you think is in the person's best interest. To figure out what is in the person's best interest, consider the person's values, preferences, and goals if you know them or can learn them. Some of these preferences may be in this form. You should also consider any behavior or communication from the person that indicates what the person currently wants.*
- 4. If this form names you as an Agent, you can also request and share the person's health information. But unless the person has said so in this form, you can do this **only** when the person is unable to make health care decisions for themselves.*