Advance Care Plan for

_____

Print Name of Patient

Instructions: Competent adults and emancipated minors may give instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and <u>either</u> witnessed <u>or</u> notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name: _____ Phone #: _____ Phone #: _____
Address:
_____

Other contact information: _____ Relation: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: _____ Phone #: _____ Phone #: _____
Address:
_____

Other contact information: _____ Relation: _____

Definitions for the following treatment terms are found on page 3.

My Care Plan

<u>Permanent</u> Unconscious Condition: These instructions apply if I become totally unaware of people or surroundings, **with little chance of ever waking up from the coma, and my condition is irreversible** (that is, it will not improve). Then, I direct that medically appropriate treatment be provided as follows:

Checking "yes" means I WANT the treatment. Checking "no" means that I DO NOT want the treatment.

CPR (Cardiopulmonary Resuscitation)	❑ Yes		❑ No
Life Support/Other Artificial Support (ex. ventilator)	❑ Yes		❑ No
Gastric tube feeding/IV fluids	❑ Yes		❑ No
Nasogastric tube feeding/IV fluids	❑ Yes		❑ No
Treatment of New Conditions (ex. pneumonia, urinary tract infections)	❑ Yes	❑ Yes, if needed for comfort	❑ No

End-Stage Illnesses: If I have an illness that has reached its final stages in spite of full treatment, then I direct that medically appropriate treatment be provided as follows. (Examples of end-stage illnesses are widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.)

Checking "yes" means I WANT the treatment. Checking "no" means that I DO NOT want the treatment.

CPR (Cardiopulmonary Resuscitation)	❑ Yes		❑ No
Life Support/Other Artificial Support (ex. ventilator)	❑ Yes		❑ No
Gastric tube feeding/IV fluids	❑ Yes		❑ No
Nasogastric tube feeding/IV fluids	❑ Yes		❑ No
Treatment of New Conditions (ex. pneumonia, urinary tract infections)	❑ Yes	❑ Yes, if needed for comfort	❑ No

<u>Permanent</u> Confusion: These instructions apply if I become unable to remember, understand or make decisions, and my condition is irreversible (that is, it will not improve). This would include late-stage dementia or brain damage that is *<u>not</u>* going to improve. Then, I direct that medically appropriate treatment be provided as follows:

Checking "yes" means I WANT the treatment. Checking "no" means that I DO NOT want the treatment.

CPR (Cardiopulmonary Resuscitation)	❑ Yes		❑ No
Life Support/Other Artificial Support (ex. ventilator)	❑ Yes		❑ No
Gastric tube feeding/IV fluids	❑ Yes		❑ No
Nasogastric tube feeding/IV fluids	❑ Yes		❑ No
Treatment of New Conditions (ex. pneumonia, urinary tract infections)	❑ Yes	❑ Yes, if needed for comfort	❑ No

Dependent in *all* Activities of Daily Living: These instructions apply if I am no longer able to talk clearly or move by myself; and I depend on others for feeding, bathing, dressing and walking; (and rehabilitation or other restorative treatment will not help). Then, I direct that medically appropriate treatment be provided as follows:

Checking "yes" means I WANT the treatment. Checking "no" means that I DO NOT want the treatment.

CPR (Cardiopulmonary Resuscitation)	❑ Yes		❑ No
Life Support/Other Artificial Support (ex. ventilator)	❑ Yes		❑ No
Gastric tube feeding/IV fluids	❑ Yes		❑ No
Nasogastric tube feeding/IV fluids	❑ Yes		❑ No
Treatment of New Conditions (ex. pneumonia, urinary tract infections)	❑ Yes	❑ Yes, if needed for comfort	❑ No

Please check and initial the one statement that most closely matches your wishes:

❑ _____ I have made my funeral and burial arrangements and do not want my health care agent to change arrangements already in place.

❑ _____ I authorize my health care agent to make arrangements for my burial, including decisions regarding cremation.

❑ _____ I do not authorize my health care agent to make arrangements for cremation, pursuant to T.C.A. § 62-5-5(b).

Other instructions, such as burial arrangements, hospice care, etc.:

_____

_____

_____

Organ donation (optional): Upon my death, I wish to make the following anatomical gift:

❑ Any organ/tissue ❑ My entire body ❑ Only the following organs/tissues:

_____

_____

[You can add pages, with your name on them, if you have more detailed instructions to include.]

Definitions

CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.

Life Support/Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps make the lungs, heart, kidneys and other organs to continue to work.

Treatment of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness. Examples of new conditions would include a new diagnosis of pneumonia, infection (such as a urinary tract infection) or pressure ulcers (also called bed sores).

Tube feeding/IV fluids: Use of gastric and nasogastric tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Signature

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your health care agent, and at least one witness must be a neutral witness, as described with the second signature line for witnesses.

Date: _____ **Signature:** ✕ _____

Patient

Witnesses:

1. I am a competent adult who is not named as the health care agent. I witnessed the patient's signature on this form.

_____
Signature of Witness

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage or adoption and I do not expect and am not entitled to any portion of the patient's estate upon his or her death under any existing will, codicil or operation of law. I am not the spouse of the patient. I am not the treating physician or clinician. I witnessed the patient's signature on this form.

_____
Signature of Witness

The document may be notarized instead of witnessed:

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the patient. The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and is under no duress, fraud or undue influence.

_____
Signature of Notary Public

My commission expires: _____

What to do with this Care Plan:

Discuss this plan with your doctor and provide a copy to your doctor(s).
Provide a copy to the persons who are your health care agent and substitute agent.
Keep a copy where it can be found if needed.
Tell your emergency contacts and closest friends or relatives that you have a care plan.

Based on the form approved by the Tennessee Dept. of Health, Board for Licensing Health Care Facilities, February 3, 2005.