BOZEMAN HEALTH
DEACONESS HOSPITAL

MY CHOICES
Advance Directive for My Health Care

_____ _____ _____
Print Your Full Name **Date of Birth** **Social Security Number.**

These directions apply only in situations when I am not able to make or communicate my health care choices directly. [Put an X through any sections you are not completing at this time.]

HEALTH CARE REPRESENTATIVE

My Representative may make ALL health care decisions for me as authorized in this document and shall be given access to all my medical records. This appointment applies whether I am expected to recover or not.

I wish to appoint a Representative: □ Yes □ No

A. I appoint_____ **as my Representative.**
Print Representative's full name.

Representative's Address_____

City_____State_____ Zip_____

Home Phone_____Cell Phone_____ Work Phone_____
My Representative's authority is effective when I cannot make health care decisions or communicate my wishes. I may revoke this authority at any time I regain these abilities (unless my attending physician and any necessary experts determine I am not capable of making decisions in my own best interest).

If, for any reason, I should need a guardian of my person designated by a court, I nominate my Representative, or Alternate Representative(s), named below.

B. Alternate Representatives

If 1). I revoke my Representative's authority; or
2). My Representative becomes unwilling or unable to act for me; or
3). My Representative is my spouse and I become legally separated or divorced.
I name the following person(s) as alternates to my Representative in the order listed.

1._____ 2._____

Address_____ Address_____
City_____ST_____ Zip_____ City_____ST_____Zip_____
Home Phone _____ Home Ph_____
Cell Phone_____ Cell Phone_____

INITIAL_____

HEALTH CARE GUIDELINES ABOUT THE END OF LIFE

EXPRESSION OF INTENT TO PHYSICIANS AND CAREGIVERS

If I should be in an incurable or irreversible physical condition, with no reasonable hope of recovery, and I am no longer able to make decisions, regarding my medical treatment; these are my wishes:

CIRCLE EACH SPECIFIC WISH BELOW:

1. I (**do**) or (**do not**) want treatment that only prolongs the dying process.
2. I **(do**) or **(do not**) want treatment to maintain my dignity, keep me comfortable and relieve me of pain.
3. I **(do**) or **(do not**) want Cardio Pulmonary Resuscitation.
4. I **(do)** or **(do not**) want mechanical ventilation (breathing).
5. If I cannot eat, I **(do)** or **(do not)** want a tube inserted in my nose, mouth, or surgically placed in my stomach to give me food.
6. If I cannot drink, I **(do)** or **(do not)** want to receive fluids through a needle or catheter placed in my body.
7. If I have a serious infection, I **(do)** or **(do not)** want antibiotics that would only prolong the dying process.

OTHER SPECIFIC WISHES: _____

_____

_____

_____

INITIAL_____

SIGNING AND WITNESSING THIS ADVANCE DIRECTIVE

A. Your signature [Sign this document in the presence of two witnesses.]

1. I revoke any prior health care advance directive or directions.
2. This document is intended to be valid in any jurisdiction in which it is presented.
3. A copy of this document is intended to have the same effect as the original.
4. Those who act as I have directed in this document shall be free from legal liability for having followed my directions.
5. If my attending physician is unwilling or unable to comply with my wishes, I direct my care be transferred to another physician.

I sign this document on the _____day of _____year_____.

_____ _____

Signature Print Full Name

Address_____

City_____ST_____Zip_____

Home Ph_____ Work Ph_____

B. Ask Your Witnesses to Read and Sign

I declare that the person who signed this document is personally known to me, and has signed these health care advance directives in my presence, and appears to be of sound mind and under no duress, fraud, or undue influence.

As a witness, I am NOT:

-The person appointed as Representative by this document;
-Financially responsible for this person's health care;
-Related to this person by blood, marriage, or adoption; and
-To the best of my knowledge, entitled to inherit any part of this person's estate under a will now existing or by operation of law.

1. _____ _____ 2._____ _____

Signature Date Signature Date

Name_____ Name_____

Address_____ Address_____

City_____ST_____ Zip_____ City_____ST_____ Zip_____

Should you choose to have this form serve as Durable Power of Attorney for Health Care, please complete notarization below:

C. Notarizing this Document (Optional)

STATE OF_____)

COUNTY OF _____)

On this _____day of _____, _____the said _____known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.

_____

Notary Public for the State of Montana

Residing at_____, MT

INITIAL_____

My commission expires:_____

CONSIDERATIONS

A. Spiritual Preferences

My religion:_____ My faith community:_____

Contact person:_____ I would like spiritual support: □ Yes □ No

B. My Preference is to die at: ☐ My Home ☐ Hospital
☐ Nursing Home ☐ Other_____

C. Donation of Organs at My Death (if eligible)
☐ I do not wish to donate any of my body, organs or tissue.
☐ I wish to donate my entire body.
☐ I wish to donate only the following: [check all that apply]
☐ Any Organs, tissues or body parts: ☐ Heart ☐ Kidneys ☐ Lungs
☐ Bone Marrow ☐ Eyes ☐ Skin ☐ Liver
☐ Others_____

D. After Death Care: [Care of my body, burial, cremation, autopsy, funeral home preference]

_____

E. Additional Directions: (Use additional pages if necessary)_____

_____

Signature _____ Date _____

F. Distributing this Document: (Optional)
I plan to send copies of this document to the following people or locations:

☐ **Representative:** ☐ **Family Member:** Relationship_____

Name_____ Name_____

☐ **Physician:** ☐ **Hospital:**

Name_____ Name_____

☐ **Clergy:** ☐ **Other:**

Name_____ Name_____

INITIAL_____