

Advance Directives

Information and
guidelines for
making choices
about your
health care





Advance Directives

Making Choices About Your Health Care Information & Guidelines

A summary like this does not answer all of your questions. We urge you to discuss your decision about your Advance Directives with your doctor, family, friends, attorney or clergy. If you have more questions, your nurse, social worker or hospital chaplain can help. Please inform your family or someone close to you about your decision. For your convenience, we have enclosed samples of the Advance Directives forms and Organ Donation Addendum, approved by the Maryland Attorney General. You may use the forms provided as is or modify them according to your specific needs or wishes. You also may wish to consult your physician or attorney for more information.

This brochure includes these Advance Directive forms:

- Planning for Future Health Care Decisions
- After My Death
- Did You Remember To...

Planning for Your Health Care

Carroll Hospital Center's goal is to provide you with compassionate, state-of-the-art medical care. We also want to help you and your family plan in advance for your health care preferences if you are unable to make these decisions for yourself because of a terminal illness or critical injury.

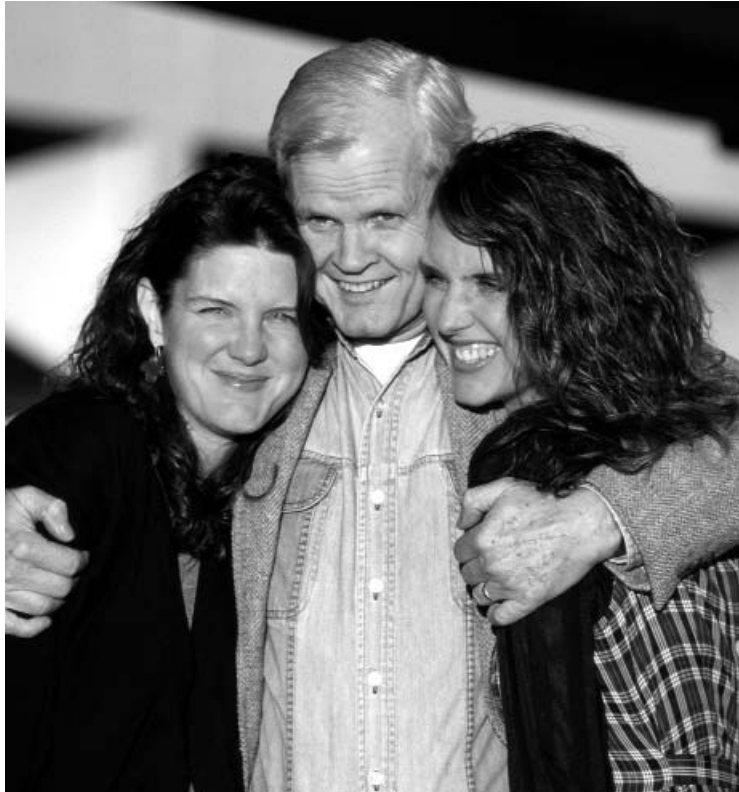
Your health care team encourages you to take steps now to control medical decisions should you be unable to speak for yourself. This brochure explains the role of Advance Directives in making these personal choices. Advance Directives protect your right to accept or refuse medical care should you become mentally or physically unable to act in your own interest.

The Hospital's Role

The Patient Self Determination Act, passed by Congress in 1990, requires hospital personnel to ask all adult patients if they have Advance Directives. Hospital staff must then document their answers and provide them with general information on Advance Directives. Changes in this law, enacted in 1993 and 1996, have made it even easier for patients to control their health care decisions. The staff of Carroll Hospital Center wants to help you understand that you have the right to make personal decisions about your options for care. Information you provide will be included in your medical record at the time of your admission and every effort will be made to comply with your written or verbal instructions.

Appointment of a Health Care Agent

This process requires a legal document that names someone you know and trust, an agent or proxy, to make health care decisions for you if you are unable to make them for yourself. In addition to authorizing your agent to make decisions on your behalf, you can identify certain treatments you want administered or withheld under specific circumstances. Your written guidance about your preferences will help your agent decide if you want life-prolonging treatment in case of a terminal illness, permanent loss of consciousness or end-stage condition. Once completed, the Appointment of a Health Care Agent document should be signed, dated, witnessed and given to your agent or physician. The individual you appoint as your agent is not permitted to witness the document. Additionally, your physician is not eligible to be appointed as your health care agent. This document can be revoked at any time by destroying it or informing your health care agent about your change of mind.



**For more information regarding
Advance Directives, call:**

Chaplain Services: 410-871-6679

Case Management Department: 410-871-7922

**For more form copies call
Health Access at 410-871-7000.**

Organ Donation

The Organ Donation Addendum allows you to decide which organs you wish to donate in the event of your death. If you choose to donate your organs, this document should be signed, dated, witnessed and given to your health care agent or physician. Like the Appointment of a Health Care Agent, this document can be revoked or amended at any time.

Discussion with Your Physician

We encourage you to discuss options for life-prolonging care with your physician, who can explain advantages and disadvantages of specific procedures. After talking with your doctor, you can decide what kinds of medical intervention you want, given particular circumstances. If your decision is written in the medical record by your physician at the time it is made, it is legally binding and will be honored by your health care providers.

No matter what your decision, the staff at Carroll Hospital Center is committed to providing excellent care and easing your pain and suffering.

Frequently Asked Questions About Advance Directives in Maryland

1. Must I use any particular form?

No. An optional form is provided, but you may change it or use a different form altogether. Of course, no health care provider may deny you care simply because you decided not to fill out a form.

2. Who can be picked as a health care agent?

Anyone who is 18 or older except, in general, an owner, operator or employee of a health care facility where a patient is receiving care.

3. Who can witness an Advance Directive?

Two witnesses are needed. Generally, any competent adult can be a witness, including your doctor or other health care provider (but be aware that some facilities have a policy against their employees serving as witnesses). If you name a health care agent, that person cannot be a witness for your Advance Directive. Also, one of the two witnesses must be someone who (i) will not receive money or property from your estate and (ii) is not the one you have named to handle your estate after your death.

4. Do the forms have to be notarized?

No, but if you travel frequently to another state, check with a knowledgeable lawyer to see if that state requires notarization.

5. Do any of these documents deal with financial matters?

No. If you want to plan for how financial matters can be handled if you lose capacity, talk with your lawyer.

6. When using these forms to make a decision, how do I show the choices that I have made?

Write your initials next to the statement that says what you want. Don't use checkmarks or Xs. If you want, you can also draw lines all the way through other statements that do not say what you want.

7. Should I fill out both Parts I and II of the Advance Directive form?

It depends on what you want to do. If all you want to do is name a health care agent, just fill out Parts I and III, and talk to the person about how they should decide issues for you. If all you want to do is give treatment instructions, fill out Parts II and III. If you want to do both, fill out all three parts.

8. Are these forms valid in another state?

It depends on the law of the other state. Most state laws recognize Advance Directives made somewhere else.

9. How can I get Advance Directive forms for another state?

Contact Caring Connections (NHPCO) at 1-800-658-8898 or on the Internet at: www.caringinfo.org.

10. To whom should I give copies of my Advance Directive?

Give copies to your doctor, your health care agent and backup

agent(s), hospital or nursing home if you will be staying there, and family members or friends who should know of your wishes.

Consider carrying a card in your wallet saying you have an Advance Directive and who to contact.

11. Does the federal law on medical records privacy (HIPAA) require special language about my health care agent?

Special language is not required, but it is prudent. Language about HIPAA has been incorporated into the form.

12. Can my health care agent or my family decide treatment issues differently from what I wrote?

It depends on how much flexibility you want to give. Some people want to give family members or others flexibility in applying the living will. Other people want it followed very strictly. Say what you want in Part II, Paragraph G.

13. Can my doctor override my living will?

Usually, no. However, a doctor is not required to provide a "medically ineffective" treatment even if a living will asks for it.

14. If I have an Advance Directive, do I also need an Emergency Medical Services Palliative Care/Do Not Resuscitate Order?

Yes. If you don't want ambulance personnel to try to resuscitate you in the event of cardiac or respiratory arrest, you must have an EMS Palliative Care/DNR Order signed by your doctor.

15. Does the EMS Palliative Care/DNR Order have to be in a particular form?

Yes. Ambulance personnel have very little time to evaluate the situation and act appropriately. So, it is not practical to ask them to interpret documents that may vary in form and content. Instead, a standardized order form has been developed. Have your doctor or health care facility contact the Maryland Institute for Emergency Medical Services System at 410-706-4367 to obtain information on EMS Palliative Care/DNR Orders.

16. Can I fill out a form to become an organ donor?

Yes. Use Part I of the "After My Death" form.

17. What about donating my body for medical education or research?

Part II of the "After My Death" form is a general statement of these wishes. The State Anatomy Board has a specific donation program, with a pre-registration form available. Call the Anatomy Board at 1-877-463-3464 for that form and additional information.



CARROLL
HOSPITAL CENTER

Advance Directive

Planning for Future Health Care Decisions

Patient Label

By: _____ Date of Birth: _____
(Print Name) (Month/Day/Year)

Using this Advance Directive form to do health care planning is completely optional. Other forms are also valid in Maryland. No matter what form you use, talk to your family and others close to you about your wishes. This form has two parts to state your wishes, and a third part for needed signatures. Part I of this form lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your health care agent. Make sure you talk to your health care agent (and any back-up agents) about this important role. Part II lets you write your preferences about efforts to extend your life in three situations: terminal condition, persistent vegetative state, and end-stage condition. In addition to your health care planning decisions, you can choose to become an organ donor after your death by filling out the form for that too. You can fill out Parts I and II of this form, or only Part I, or only Part II. Use the form to reflect your wishes, then sign in front of two witnesses (Part III). If your wishes change, make a new Advance Directive. Make sure you give a copy of the completed form to your health care agent, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

PART I: SELECTION OF HEALTH CARE AGENT

A. Selection of Primary Agent

I select the following individual as my agent to make health care decisions for me:

Name: _____

Address: _____

Telephone Number (Home and Cell): _____

B. Selection of Back-up Agents

(Optional; form valid if left blank)

1. If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then

I select the following person to act in this capacity:

Name: _____

Address: _____

Telephone Number (Home and Cell): _____



Patient Label

2. If my primary agent and my first back-up agent cannot be contacted in time or for any reason are unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

Name: _____

Address: _____

Telephone Number (Home and Cell): _____

C. Powers and Rights of Health Care Agent

I want my agent to have full power to make health care decisions for me, including the power to:

1. Consent or not to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes;
2. Decide who my doctor and other health care providers should be; and
3. Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.
4. I also want my agent to:
 - a. Ride with me in an ambulance if ever I need to be rushed to the hospital; and
 - b. Be able to visit me if I am in a hospital or any other health care facility.

THIS ADVANCE DIRECTIVE DOES NOT MAKE MY AGENT RESPONSIBLE FOR ANY OF THE COSTS OF MY CARE.

This power is subject to the following conditions or limitations: (Optional; form valid if left blank)

D. How my Agent is to Decide Specific Issues

I trust my agent's judgment. My agent should look first to see if there is anything in Part II of this Advance Directive that helps decide the issue. Then, my agent should think about the conversations we have had, my religious and other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my agent is to make decisions for me that my agent believes are in my best interest. In doing so, my agent should consider the benefits, burdens, and risks of the choices presented by my doctors.



Patient Label

E. People My Agent Should Consult (Optional; form valid if left blank)

In making important decisions on my behalf, I encourage my agent to consult with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to consult or my agent's power to make decisions.

| Name(s) | Telephone Number(s) |
|---------|---------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

F. In Case of Pregnancy (Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my agent shall follow these specific instructions:

G. Access to my Health Information – Federal Privacy Law (HIPAA) Authorization

1. If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own health care decisions, I authorize my doctor to disclose protected health information which relates to that issue.
2. Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.
3. For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

Patient Label

H. Effectiveness of this Part

(Read both of these statements carefully. Then, initial **one** only.)

My agent's power is in effect:

1. Immediately after I sign this document, subject to my right to make any decision about my health care if I want and am able to.

0 _____

OR

2. Whenever I am not able to make informed decisions about my health care, either because the doctor in charge of my care (attending physician) decides that I have lost this ability temporarily, or my attending physician and a consulting doctor agree that I have lost this ability permanently.

0 _____

If the only thing you want to do is select a health care agent, skip Part II. Go to Part III to sign and have the Advance Directive witnessed. If you also want to write your treatment preferences, go to Part II. Also consider becoming an organ donor, using the separate form for that.

PART II: TREATMENT PREFERENCES (“LIVING WILL”)**A. Statement of Goals and Values** (Optional; form valid if left blank)

I want to say something about my goals and values, and especially what’s most important to me during the last part of my life:

B. Preference in Case of Terminal Condition

(If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that my death from a terminal condition is imminent, even if life-sustaining procedures are used:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

0 _____

OR

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

0 _____

OR

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

0 _____

C. Preference in Case of Persistent Vegetative State

(If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life.
I do not want to receive nutrition and fluids by tube or other medical means.

0 _____

OR

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

0 _____

OR

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

0 _____

D. Preference in Case of End-Stage Condition

(If you want to state what your preference is, initial one only. If you do not want to state a preference here, cross through the whole section.)

If my doctors certify that I am in an end-state condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

1. Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life.
I do not want to receive nutrition and fluids by tube or other medical means.

0 _____

OR

Patient Label

2. Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

0 _____

OR

3. Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

0 _____

E. Pain Relief

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

F. In Case of Pregnancy (Optional, for women of child-bearing years only; form valid if left blank)

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

G. Effect of Stated Preferences (Read both of these statements carefully. Then, initial **one** only.)

1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

0 _____

OR

2. I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

0 _____



Patient Label

PART III: SIGNATURE AND WITNESSES

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this Advance Directive and that I understand its purpose and effect. I also understand that this document replaces any similar Advance Directive I may have completed before this date.

Signature of Declarant

Date

The Declarant signed or acknowledged signing this document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this Advance Directive.

Signature of Witness

Date

Telephone Number(s)

Signature of Witness

Date

Telephone Number(s)

(Note: Anyone selected as a health care agent in Part I may not be a witness. Also, at least one of the witnesses must be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant's death. Maryland law does not require this document to be notarized.)



Advance Directive

After My Death

(This document is optional. Do only what reflects your wishes.)

Patient Label

By: _____ Date of Birth: _____
(Print Name) (Month/Day/Year)

PART I: ORGAN DONATION

(Initial the ones that you want. Cross through any that you do not want.)

Upon my death I wish to donate:

- Any needed organs, tissues, or eyes. 0 _____
- Only the following organs, tissues, or eyes: 0 _____
- _____
- _____

I authorize the use of my organs, tissues, or eyes:

- For transplantation 0 _____
- For therapy 0 _____
- For research 0 _____
- For medical education 0 _____
- For any purpose authorized by law 0 _____

I understand that no vital organ, tissue, or eye may be removed for transplantation until after I have been pronounced dead. *This document is not intended to change anything about my health care while I am still alive.* After death, I authorize any appropriate support measures to maintain the viability for transplantation of my organs, tissues, and eyes until organ, tissue, and eye recovery has been completed. I understand that my estate will not be charged for any costs related to this donation.

PART II: DONATION OF BODY

After any organ donation indicated in Part I, I wish my body to be donated for use in a medical study program.

0 _____



Patient Label

PART III: DISPOSITION OF BODY AND FUNERAL ARRANGEMENTS

I want the following person to make decisions about the disposition of my body and my funeral arrangements: (Either initial the first or fill in the second.)

The health care agent who I named in my Advance Directive. 0 _____

OR this person:

Name: _____

Address: _____

Telephone Number (Home and Cell): _____

If I have written my wishes below, they should be followed. If not, the person I have named should decide based on conversations we have had, my religious or other beliefs and values, my personality, and how I reacted to other peoples' funeral arrangements. My wishes about the disposition of my body and my funeral arrangements are:

PART IV: SIGNATURE AND WITNESSES

By signing below, I indicate that I am emotionally and mentally competent to make this donation and that I understand the purpose and effect of this document.

Signature of Donor Date

The Donor signed or acknowledged signing the foregoing document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.

Signature of Witness Date

Telephone No:

Signature of Witness Date

Telephone No:

Advance Directive

Patient Label

Did you remember to...

_____ Fill out Part I if you want to name a health care agent?

_____ Name one or two back-up agents in case your first choice as health care agent is not available when needed?

_____ Talk to your agents and back-up agent about your values and priorities, and decide whether that's enough guidance or whether you also want to make specific health care decisions in the Advance Directive?

_____ If you want to make specific decisions, fill out Part II, choosing carefully among alternatives?

_____ Sign and date the Advance Directive in Part III, in front of two witnesses who also need to sign?

_____ Look over the "After My Death" form to see if you want to fill out any part of it?

_____ Make sure your health care agent (if you named one), your family, and your doctor know about your advance care planning?

_____ Give a copy of your Advance Directive to your health care agent, family members, doctor, and hospital or nursing home if you are a patient there?