

Advance Directives

Important information on health care decision-making: You Have the Right to Decide

The documents provided in this package are being presented to you in accordance with the Federal Patient Self-determination Act, the Health Care Advance Directives Statute of Florida, and as a public service of Lee Health.

Name: _____

Date of Birth: _____



Revised August 2023

120134218-5732

Frequently Asked Questions Concerning Advance Directives

WHO NEEDS TO BE CONCERNED ABOUT ADVANCE DIRECTIVES?

All adult patients (age 18 years and older) should understand advance directives. Federal law requires certain facilities, including hospitals, nursing homes and home health agencies provide written information about an individual's rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. Further, those facilities must document in a prominent part of the individual's current medical record whether or not the individual has executed an advance directive. Every adult person who becomes a patient in Lee Memorial Health System facilities should be asked whether they have written an advance directive. Advance directives are not required to receive care in Lee Memorial Health System, but are provided to you to be able to document your wishes concerning treatment.

WHY DOES LEE MEMORIAL PROVIDE THIS INFORMATION?

The United States Congress passed a law in 1990 called the "Patient Self-Determination Act". This law requires that all health care organizations provide written information to patients regarding their rights to make decisions about their own medical care. This includes the right to accept or refuse medical or surgical treatment.

WHAT IS AN ADVANCE DIRECTIVE?

An advance directive is a set of instructions you have prepared regarding your medical care. They may describe what treatment you do or do not want and serve to convey your wishes to the medical team in the event you are not able to give directions yourself.

WHO CAN BE A WITNESS TO A LIVING WILL?

Generally, any adult can be, but a spouse or blood relative can be only ONE of the witnesses; the second witness should be someone who is not related to you. The person you have named as your surrogate should not be one of the witnesses.

WHAT IS A LIVING WILL?

A living will contains specific instructions about what you want done regarding withholding or withdrawing life-prolonging procedures in the event you have a terminal condition, an end-stage condition, or are in a persistent vegetative state.

WHAT IS A DESIGNATION OF HEALTH CARE SURROGATE (DHCS)?

A DHCS is a document you sign appointing a person (surrogate) you trust to make health care decisions for you if you are temporarily or permanently unable to make health care decisions for yourself. It is important you talk with your surrogate and let the surrogate know your wishes about your medical care and treatment, so that your surrogate will make the decisions based upon your desires.

WHO CAN BE A WITNESS TO A HEALTH CARE SURROGATE DESIGNATION?

A spouse or blood relative can be one of the witnesses, the second witness should be someone who is not related to you. The person designated as your surrogate cannot be a witness.

WHEN DOES MY LIVING WILL OR OTHER ADVANCE DIRECTIVE ACTUALLY GO INTO EFFECT?

Your physician, after evaluating your condition, will call in another physician for a second opinion. If both determine that you have a terminal condition, an end-stage condition, or a persistent vegetative state, your living will goes into effect. If you have designated a surrogate and it is determined by your physician that you do not have the “capacity”, or ability, to make your own decisions, then your surrogate would be asked to provide consent for you.

WHAT IF I HAVE NOT MADE AN ADVANCE DIRECTIVE OR CANNOT SIGN MY NAME ON A LIVING WILL?

You can give verbal instructions to your physician and family. However, it is more helpful for you to put your wishes in writing.

WHAT IF I CHANGE MY MIND AND WANT TO DELETE ALL OR PART OF MY LIVING WILL?

Your advance directive can be revoked at any time by doing any of the following things: a) signing a written statement saying that you revoke it; b) physically tearing up the directive or have someone else tear it up in your presence; c) orally expressing that you revoke it; d) executing another advance directive that is different than the previous one. The most important thing to remember is to tell your doctor, family or friends what you want.

CAN MY LIFE INSURANCE COMPANY CANCEL MY LIFE INSURANCE FOR SAYING I WANT LIFE SUPPORT WITHHELD OR WITHDRAWN?

No. Florida law states that no policy of life insurance will be invalidated by you making these choices. Also, you cannot be required to make an advance directive as a condition for getting insurance or being admitted to a hospital.

I SIGNED A LIVING WILL IN ANOTHER STATE. IS IT VALID HERE?

Normally, yes! Florida will recognize an advance directive executed in another state provided that it meets Florida's state requirements.

WHERE SHOULD I KEEP MY ADVANCE DIRECTIVE?

Your advance directive is your "voice" and should serve to give your instructions if you cannot. It is important that it be in an accessible place and that your surrogate, family and physician all have a copy of it. You should also bring a copy with you each time you are admitted to the hospital, or ask someone to bring it for you.

WHERE CAN I GET AN ADVANCE DIRECTIVE?

There is a form included in this booklet that you are free to use. There are other versions of living wills available. This one is the example provided in Florida Statutes. You may use another version of a living will, but it may be advisable to make sure that it meets Florida law requirements.

DO I NEED A LAWYER TO MAKE A LIVING WILL OR DESIGNATE A HEALTH CARE SURROGATE?

No. You can execute a living will or health care surrogate designation without a lawyer. However, if you need to prepare documents related to financial decision-making, such as a Durable Power of Attorney, you would be wise to ask for the assistance of an attorney. The information in this packet is related to health care decision-making.

Lee Health hopes that this booklet has helped answer questions about living wills and advance directives. However, if you have further questions and would like more assistance, please feel free to call us at:

343-2940—Medical Social Work, Department of Care Management

343-5199—Spiritual Services Department

424-3765—Older Adult Services

432-3450—HealthPark Care & Rehabilitation Center Social Services

343-2000—Guest Services

Living Will

(Please print your name)

(A life-prolonging procedure means any medical procedure, treatment, or intervention, including artificially provided sustenance and hydration, which sustains, restores or supplants a spontaneous vital function.)

(You should give your physician, family members or a close friend a copy of the document.)

(You may wish to give special consideration to cardiopulmonary resuscitation, ventilators for breathing, artificial tube feedings or fluids given by tubes, kidney dialysis, surgery, or antibiotics.)

YOU SIGN HERE

(If you are unable to sign, a witness must sign your name at your direction and in your presence).

WITNESS SIGN HERE

(Must be signed in the presence of two (2) witnesses, one of whom is neither a spouse nor a blood relative.)

WITNESS SIGN HERE

Declaration made this ___ day of _____, 20 ____

I, _____, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the following circumstances, and I do hereby declare:

If at any time I am incapacitated and:

_____ I have a terminal condition, or

_____ I have an end-stage condition, or

_____ I am in a persistent vegetative state

Initial all that apply

and if my primary physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I would be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain. It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal. In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate the following person as my surrogate to carry out the provisions of this declaration.

Name _____

Address _____

City _____ State _____ Zip Code _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional instructions (optional):

Signed _____

Witness _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

Witness _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

BLANK PAGE

Designation Of Health Care Surrogate

I, _____, designate as my health care surrogate under s. 765.202, Florida Statutes:

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

If my health care surrogate is not willing, able, or reasonably available to perform his or her duties, I designate as my alternate health care surrogate:

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone _____

INSTRUCTIONS FOR HEALTH CARE

I authorize my health care surrogate to:

_____ Receive any of my health information, whether oral or recorded in any form or medium, that:
(Initials)

1. Is created or received by a health care provider, health care facility, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and
2. Relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.

I further authorize my health care surrogate to:

_____ Make all health care decisions for me, which means he or she has the authority to:
(Initials)

1. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
2. Apply on my behalf for private, public, government, or veterans' benefits to defray the cost of health care.
3. Access my health information reasonably necessary for the health care surrogate to make decisions involving my health care and to apply for benefits for me.
4. Decide to make an anatomical gift pursuant to part V of chapter 765, Florida Statutes.

Specific instructions and restrictions: _____

While I have decision-making capacity, my wishes are controlling and my physicians and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation.

To the extent I am capable of understanding, my health care surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

THIS HEALTH CARE SURROGATE DESIGNATION IS NOT AFFECTED BY MY SUBSEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA STATUTES.

PURSUANT TO SECTION 765.104, FLORIDA STATUTES, I UNDERSTAND THAT I MAY, AT ANY TIME WHILE I RETAIN MY CAPACITY, REVOKE OR AMEND THIS DESIGNATION BY:

- (1) SIGNING A WRITTEN AND DATED INSTRUMENT WHICH EXPRESSES MY INTENT TO AMEND OR REVOKE THIS DESIGNATION;
- (2) PHYSICALLY DESTROYING THIS DESIGNATION THROUGH MY OWN ACTION OR BY THAT OF ANOTHER PERSON IN MY PRESENCE AND UNDER MY DIRECTION;
- (3) VERBALLY EXPRESSING MY INTENTION TO AMEND OR REVOKE THIS DESIGNATION; OR
- (4) SIGNING A NEW DESIGNATION THAT IS MATERIALLY DIFFERENT FROM THIS DESIGNATION.

MY HEALTH CARE SURROGATE'S AUTHORITY BECOMES EFFECTIVE WHEN MY PRIMARY PHYSICIAN DETERMINES THAT I AM UNABLE TO MAKE MY OWN HEALTH CARE DECISIONS UNLESS I INITIAL EITHER OR BOTH OF THE FOLLOWING BOXES:

IF I INITIAL THIS BOX [____], MY HEALTH CARE SURROGATE'S AUTHORITY TO RECEIVE MY HEALTH INFORMATION TAKES EFFECT IMMEDIATELY.

IF I INITIAL THIS BOX [____], MY HEALTH CARE SURROGATE'S AUTHORITY TO MAKE HEALTH CARE DECISIONS FOR ME TAKES EFFECT IMMEDIATELY. PURSUANT TO SECTION 765.204(3), FLORIDA STATUTES, ANY INSTRUCTIONS OR HEALTH CARE DECISIONS I MAKE, EITHER VERBALLY OR IN WRITING, WHILE I POSSESS CAPACITY SHALL SUPERCEDE ANY INSTRUCTIONS OR HEALTH CARE DECISIONS MADE BY MY SURROGATE THAT ARE IN MATERIAL CONFLICT WITH THOSE MADE BY ME.

SIGNATURES: Sign and date the form here:

Print Your Name _____

Sign Your Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

SIGNATURES OF WITNESSES:

Note: A spouse or blood relative can be one of the witnesses; the second witness should be someone who is not related to you. The person designated as your surrogate cannot be a witness.

First Witness

Print Your Name _____

Sign Your Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

Second Witness

Print Your Name _____

Sign Your Name _____ Date _____

Address _____

City _____ State _____ Zip Code _____

