Guidelines for Completing
Advance Directive for Health Care

Instructions

You have the right to give instructions about your own health care. You also have the right to name someone to make health care decisions for you.

The first part of the Advance Directive for Health Care form lets you write down who you want to speak for you if you are unable to speak for yourself. If you use the form, you may complete or change any part of it or all of it. You are free to use a different form.

Tennessee's model Advance Directive form can serve one or both of these functions:

- Appoint a Health Care Agent / Durable Power of Attorney for Healthcare
- Instructions about the Health Care you want

The Advance Directive for Health Care Form is divided into five parts to assist with the understanding of each part.

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

ADVANCE DIRECTIVE FOR HEALTH CARE*
(Tennessee)

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.

Part 1: Health Care Agent

Name a person as your **agent** who will make health care decisions for you if you are unable to make your own decisions. You can also choose to have your agent make decisions for you right away, even if you are still able to make your own decisions.

Also name an **alternate agent** to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Your **agent** may make all health care decisions for you, unless you limit the authority of your agent. If you want to limit the authority of your agent the form includes a place for this. If you choose not to limit the authority of your agent, your agent will have the right to:

- Consent or refuse to consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.
- Choose or discharge health care providers and institutions (hospital, doctors, etc.).
- Agree or disagree to diagnostic tests, surgical procedures, and medication plans.
- Agree or disagree with providing, withholding, or withdrawal of artificial feeding and fluids and all other forms of health care, including cardiopulmonary resuscitation (CPR).

Part I Agent: I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name:_____ Relation:_____ Home Phone:_____ Work Phone: _____
Address:_____ Mobile Phone:_____ Other Phone: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name:_____ Relation:_____ Home Phone:_____ Work Phone: ____
Address:_____ Mobile Phone:_____ Other Phone: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Part 2: Instructions for Health Care Professionals and Family Members

You can give specific instructions about any aspect of your health care, whether or not you have appointed an agent. There are choices provided on the form to help you write down your wishes regarding providing, withholding or withdrawal of treatment.
You can also add to the choices you have made or write out any additional wishes. You do not need to fill out part 2 of this form if you want to allow your agent to make any decisions about your health care that he/she believes best for you without adding your specific instructions.

Part 2 Indicate Your Wishes for Quality of Life: By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition**: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**Permanent Confusion**: I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living**: I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses**: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds 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.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Life Support / Other Artificial Support**: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes ☐ No	**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.
☐ Yes ☐ No	**Tube feeding/IV fluids**: Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Part 3: Other instructions, such as hospice care, burial arrangements, etc.:

Part 3 Other instructions, such as hospice care, burial arrangements, etc.: _____

_____

_____

_____

_____

(Attach additional pages if necessary)

You may choose to complete or leave this blank – does not affect the rest of the form

Part 4: Organ donation: You can write down your wishes about donating your bodily organs and tissues following your death.

Part 4 Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

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

_____

☐ No organ/tissue donation

_____

You may choose to complete or leave this blank – does not affect the rest of the form.

Part 5: Signature and Witnesses

After completing the form, **sign and date it** in the section provided in the presence of witnesses. The form must be signed **by two competent adult witnesses ("Block A") or** acknowledged before a notary public ("Block B"). **A notary is not required if the form is signed by two witnesses and witnesses are not required if signed by a notary.**

Part 5 Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: _____ Date: _____
(Patient)

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

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

   _____
   Signature of witness number 1

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 would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

   _____
   Signature of witness number 2

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

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 under no duress, fraud, or undue influence.

My commission expires: _____

_____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

You have the right to change or revoke your Advance Directive at any time.

If you are in a health care facility and have questions about completing the Advance Directive, please ask to speak to a Chaplain or Social Worker.

Please complete this form in English so your caregivers can understand your directions.