

# Health Care Advance Directives

## The Patient's Right to Decide

Every competent adult has the right to make decisions concerning his or her own health, including the right to choose or refuse medical treatment.

When a person becomes unable to make decisions due to a physical or mental change, such as being in a coma or developing dementia (like Alzheimer's disease), they are considered incapacitated. Only your primary physician can determine if you are incapacitated. To make sure that an incapacitated person's decisions about health care will still be respected, the Florida legislature enacted legislation pertaining to health care advance directives (Chapter 765, Florida Statutes). The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures; to designate another individual to make treatment decisions if the person becomes unable to make his or her own decisions; and/or to indicate the desire to make an anatomical donation after death. Additionally, the law states that you do not have to be incapacitated to elect a health care surrogate to make your decisions.

By law hospitals, nursing homes, home health agencies, hospices, and health maintenance organizations (HMOs) are required to provide their patients with written information, such as this pamphlet, concerning health care advance directives. The state rules that require this include 58A-2.0232, 59A-3.254, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code.

## Questions About Health Care Advance Directives

### What is an advance directive?

It is a written or oral statement about how you want medical decisions made should you not be able to make them yourself and/or it can express your wish to make an anatomical donation after death. Some people make advance directives when they are diagnosed with a life-threatening illness. Others put their wishes into writing while they are healthy, often as part of their estate planning.

Three types of advance directives are:

- A Living Will
- A Health Care Surrogate Designation (also available: Health Care Surrogate for a Minor)
- An Anatomical Donation

You might choose to complete one, two, or all three of these forms. This pamphlet provides information to help you decide what will best serve your needs.

### What is a living will?

It is a written or oral statement of the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes effect while you are still living.

You may wish to speak to your health care provider or attorney to be certain you have completed the living will in a way that your wishes will be understood.

**What is a health care surrogate designation?**

It is a document naming another person as your representative to make medical decisions for you if you are unable to make them yourself. You can include instructions about any treatment you want or do not want, similar to a living will. You can also designate an alternate surrogate.

**Which is best?**

Depending on your individual needs you may wish to complete any one or a combination of the three types of advance directives.

**What is an anatomical donation?**

It is a document that indicates your wish to donate, at death, all or part of your body. This can be an organ and tissue donation to persons in need, or donation of your body for training of health care workers. You can indicate your choice to be an organ donor by designating it on your driver's license or state identification card (at your nearest driver's license office), signing a uniform donor form (seen elsewhere in this pamphlet), or expressing your wish in a living will.

**Am I required to have an advance directive under Florida law?**

No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive, decisions about your health care or an anatomical donation may be made for you by a court-appointed guardian, your wife or husband, your adult child, your parent, your adult sibling, an adult relative, or a close friend.

The person making decisions for you may or may not be aware of your wishes. When you make an advance directive, and discuss it with the significant people in your life, it will better assure that your wishes will be carried out the way you want.

**Must an attorney prepare the advance directive?**

No, the procedures are simple and do not require an attorney, though you may choose to consult one. However, an advance directive, whether it is a written document or an oral statement, needs to be witnessed by two individuals. At least one of the witnesses cannot be a spouse or a blood relative.

**Where can I find advance directive forms?**

Florida law provides a sample of each of the following forms: a living will, a health care surrogate, and an anatomical donation. Elsewhere in this pamphlet we have included sample forms as well as resources where you can find more information and other types of advance directive forms.

**Can I change my mind after I write an advance directive?**

Yes, you may change or cancel an advance directive at any time. Any changes should be written, signed and dated. However, you can also change an advance directive by oral statement; physical destruction of the advance directive; or by writing a new advance directive.

If your driver's license or state identification card indicates you are an organ donor, but you no longer want this designation, contact the nearest driver's license office to cancel the donor designation and a new license or card will be issued to you.

**What if I have filled out an advance directive in another state and need treatment in Florida?**

An advance directive completed in another state, as described in that state's law, can be honored in Florida.

### **What should I do with my advance directive if I choose to have one?**

- If you designate a health care surrogate and an alternate surrogate be sure to ask them if they agree to take this responsibility, discuss how you would like matters handled, and give them a copy of the document.
- Make sure that your health care provider, attorney, and the significant persons in your life know that you have an advance directive and where it is located. You also may want to give them a copy.
- Set up a file where you can keep a copy of your advance directive (and other important paperwork). Some people keep original papers in a bank safety deposit box. If you do, you may want to keep copies at your house or information concerning the location of your safety deposit box.
- Keep a card or note in your purse or wallet that states that you have an advance directive and where it is located.
- If you change your advance directive, make sure your health care provider, attorney and the significant persons in your life have the latest copy.

If you have questions about your advance directive you may want to discuss these with your health care provider, attorney, or the significant persons in your life.

### **More Information On Health Care Advance Directives**

Before making a decision about advance directives you might want to consider additional options and other sources of information, including the following:

- As an alternative to a health care surrogate, or in addition to, you might want to designate a durable power of attorney. Through a written document you can name another person to act on your behalf. It is similar to a health care surrogate, but the person can be designated to perform a variety of activities (financial, legal, medical, etc.). You can consult an attorney for further information or read Chapter 709, Florida Statutes.

If you choose someone as your durable power of attorney be sure to ask the person if he or she will agree to take this responsibility, discuss how you would like matters handled, and give the person a copy of the document.

- If you are terminally ill (or if you have a loved one who is in a persistent vegetative state) you may want to consider having a pre-hospital Do Not Resuscitate Order (DNRO). A DNRO identifies people who do not wish to be resuscitated from respiratory or cardiac arrest. The pre-hospital DNRO is a specific yellow form available from the Florida Department of Health (DOH). Your attorney, health care provider, or an ambulance service may also have copies available for your use. You, or your legal representative, and your physician sign the DNRO form. More information is available on the DOH website, [www.doh.state.fl.us](http://www.doh.state.fl.us) or [www.MyFlorida.com](http://www.MyFlorida.com) (type DNRO in these website search engines) or call (850) 245-4440.

When you are admitted to a hospital the pre-hospital DNRO may be used during your hospital stay or the hospital may have its own form and procedure for documenting a Do Not Resuscitate Order.

- If a person chooses to donate, after death, his or her body for medical training and research the donation will be coordinated by the Anatomical Board of the State of Florida. You, or your survivors, must arrange with a local funeral home, and pay, for a preliminary embalming and transportation of the body to the Anatomical Board located in Gainesville, Florida. After being used for medical education or research, the body will ordinarily be cremated. The cremains will be

returned to the loved ones, if requested at the time of donation, or the Anatomical Board will spread the cremains over the Gulf of Mexico. For further information contact the Anatomical Board of the State of Florida at (800) 628-2594 or [www.med.ufl.edu/anatbd](http://www.med.ufl.edu/anatbd).

- If you would like to learn more on organ and tissue donation, please visit the Joshua Abbott Organ and Tissue Donor Registry at [www.DonateLifeFlorida.org](http://www.DonateLifeFlorida.org) where you can become organ, tissue and eye donors online. If you have further questions about organ and tissue donation you may want to talk to your health care provider.
- Various organizations also make advance directive forms available. One such document is “Five Wishes” that includes a living will and a health care surrogate designation. “Five Wishes” gives you the opportunity to specify if you want tube feeding, assistance with breathing, pain medication, and other details that might bring you comfort such as what kind of music you might like to hear, among other things. You can find out more at:

Aging with Dignity  
[www.AgingWithDignity.org](http://www.AgingWithDignity.org)  
(888) 594-7437

Other resources include:

American Association of Retired Persons (AARP)  
[www.aarp.org](http://www.aarp.org)  
(Type “advance directives” in the website’s search engine)

Your local hospital, nursing home, hospice, home health agency, and your attorney or health care provider may be able to assist you with forms or further information.

Brochure: End of Life Issues  
[www.FloridaHealthFinder.gov](http://www.FloridaHealthFinder.gov)  
(888) 419-3456

LIVING WILL

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_, (20 \_\_\_\_), I \_\_\_\_\_, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and:

\_\_\_\_\_ (initial) I have a terminal condition, or

\_\_\_\_\_ (initial) I have an end stage condition, or

\_\_\_\_\_ (initial) I am in a persistent vegetative state, and if my primary physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such a 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 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, as my surrogate to carry out the provisions of this declaration:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

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

Additional Instructions (optional):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Signed) \_\_\_\_\_

Witness Signatures:

Witness: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

Witness: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_

*At least one witness must not be a husband or wife or a blood relative of the principal.*

**DESIGNATION OF HEALTH CARE SURROGATE**

I, \_\_\_\_\_, designate as my health care surrogate under S. 765.202, Florida Statutes:

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
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: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_

**INSTRUCTIONS FOR HEALTH CARE**

I authorize my health care surrogate to: (Initials required in blank spaces below.)

\_\_\_\_\_ Receive any of my health information, whether oral or recorded in any form or medium, that:

- 1. Is created or received by a health care provider, health care facility, health plan, public health, 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:

- 3. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
- 4. Apply on my behalf for private, public, government, or veteran's benefits to defray the cost of health care.
- 5. 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.

\_\_\_\_\_ 6. 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 physician 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 that 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 States, any instructions of health care decisions I make, either verbally or in writing, while I possess capacity shall supersede 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:

_____	Date	_____	Sign your name
_____	Address	_____	Print your name
_____	City, State		

Signatures of Witnesses:

First Witness

_____	Print name
_____	Address
_____	City, State
_____	Signature
_____	Date

Second Witness

_____	Print Name
_____	Address
_____	City, State
_____	Signature
_____	Date



**DESIGNATION OF HEALTH CARE SURROGATE  
FOR MINOR**

I/We, \_\_\_\_\_ (name/names), the (check the box that applies,)  natural guardian(s) as defined in s. 744.301(1), Florida Statutes;  legal custodian(s);  legal guardian(s) of the following minor(s):

\_\_\_\_\_,  
\_\_\_\_\_,  
\_\_\_\_\_

Pursuant to s. 765.2035, Florida Statutes, designate the following person to act as my/our surrogate for health care decisions for such minor(s) in the event that I/we am/are not able or reasonably unavailable to provide consent for medical treatment and surgical and diagnostic procedures:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

If my/our designated health care surrogate for a minor is not willing, able, or reasonably available to perform his or her duties, I/we designate the following person as my/our alternate health care surrogate for a minor:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I/We authorize and request all physicians, hospitals, or other providers of medical services to follow the instructions of my/our surrogate or alternate surrogate, as the case may be, at any time and under any circumstances whatsoever, with regard to medical treatment and surgical and diagnostic procedures for a minor, provided the medical care and treatment of any minor is on the advice of a licensed physician.

I/We fully understand that this designation will permit my/our designee to make health care decisions for a minor and to provide, withhold, or withdraw consent on my/our behalf, to apply for public benefits to defray the cost of health care, and to authorize the admission or transfer of a minor to or from a health care facility.

I/We will notify and send a copy of this document to the following person(s) other than my/our surrogate, so that they may know the identity of my/our surrogate:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

**WITNESSES:**

1. Name: \_\_\_\_\_

Date: \_\_\_\_\_

2. Name: \_\_\_\_\_

Date: \_\_\_\_\_

## Uniform Donor Form

The undersigned hereby makes this anatomical gift, if medically acceptable, to take effect on death. The words and marks below indicate my desires:

I give:

(a) \_\_\_\_\_ any needed organs or parts

(b) \_\_\_\_\_ only the following organs or parts for the purpose of transplantation, therapy, medical research, or education:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(c) \_\_\_\_\_ my body for anatomical study if needed. Limitations or special wishes, if any:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signed by the donor and the following witnesses in the presence of each other:

Donor's Signature \_\_\_\_\_ Donor's Date of Birth \_\_\_\_\_

Date Signed \_\_\_\_\_ City and State \_\_\_\_\_

Witness \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Witness \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

You can use this form to indicate your choice to be an organ donor. Or you can designate it on your driver's license or state identification card (at your nearest driver's license office).

The card below may be used as a convenient method to inform others of your health care advance directives. Complete the card and cut it out. Place in your wallet or purse. You can also make copies and place another one on your refrigerator, in your car glove compartment, or other easy to find place.

<p><b>Health Care Advance Directives</b></p> <p>I, _____ have created the following Advance Directives:</p> <p>___ Living Will</p> <p>___ Health Care Surrogate Designation</p> <p>___ Anatomical Donation</p> <p>___ Other (specify) _____</p> <p>----- FOLD -----</p> <p><b>Contact:</b> Name _____</p> <p>Address _____ _____ _____</p> <p>Phone _____</p> <p>Signature _____ Date _____</p>
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