

THIS FORM IS PROVIDED AS AN EXAMPLE FOR YOU TO REVIEW WITH YOUR FAMILY AND ADVISORS THAT YOU TRUST. THIS FORM CONVEYS EXTREMELY STRONG RIGHTS AND POWERS TO OTHER PEOPLE OVER YOUR PROPERTY, ASSETS, INCOME, LIABILITIES/DEBT, CHILDREN, AND MEDICAL CARE. THESE PEOPLE DO NOT HAVE SUCH RIGHTS UNTIL YOU GIVE THEM THE RIGHTS WITH THIS FORM. YOU SHOULD NOT FILL OUT THIS FORM OR COMPLETE IT WITHOUT SPEAKING WITH AN ATTORNEY AND RECEIVING ADVICE ABOUT THE POWERS THAT YOU ARE GIVING OTHER PEOPLE AND ITS LEGAL IMPACT.

YOU SHOULD NOT COMPLETE THIS FORM WITHOUT SIGNIFICANT THOUGHT AND ADVICE FROM EXPERTS. YOU ARE ADVISED TO SPEAK WITH AN ATTORNEY BEFORE COMPLETING IT TO FULLY UNDERSTAND ITS IMPACT UPON YOUR RIGHTS AND TO HAVE THEM ASSIST YOU IN COMPLETING THE FORM.

YOU SHOULD NOT COMPLETE THIS FORM UNTIL YOU FULLY UNDERSTAND IT AND ITS IMPACT UPON YOUR RIGHTS AND SPEAKING WITH AN ATTORNEY.

ESTE FORMULARIO SE PROPORCIONA COMO UN EJEMPLO PARA QUE USTED LO REVISE CON SU FAMILIA Y CON ASESORES DE SU CONFIANZA. ESTE FORMULARIO OTORGA DERECHOS Y PODERES MUY AMPLIOS A OTRAS PERSONAS SOBRE SU PROPIEDAD, BIENES, INGRESOS, OBLIGACIONES/DEUDAS, HIJOS Y ATENCIÓN MÉDICA. ESTAS PERSONAS NO TIENEN TALES DERECHOS HASTA QUE USTED SE LOS OTORQUE MEDIANTE ESTE FORMULARIO. NO DEBE LLENAR NI COMPLETAR ESTE FORMULARIO SIN HABLAR CON UN ABOGADO Y RECIBIR ASESORAMIENTO SOBRE LOS PODERES QUE ESTÁ OTORGANDO A OTRAS PERSONAS Y SU IMPACTO LEGAL.

NO DEBE COMPLETAR ESTE FORMULARIO SIN UNA REFLEXIÓN PROFUNDA Y SIN ASESORAMIENTO DE EXPERTOS. SE LE RECOMIENDA HABLAR CON UN ABOGADO ANTES DE COMPLETARLO PARA COMPRENDER COMPLETAMENTE SU IMPACTO EN SUS DERECHOS Y PARA QUE LE ASISTA EN SU COMPLETACIÓN.

NO DEBE COMPLETAR ESTE FORMULARIO HASTA QUE LO ENTIENDA COMPLETAMENTE Y COMPRENDA SU IMPACTO EN SUS DERECHOS, Y HASTA HABER HABLADO CON UN ABOGADO.

This form lets you have a say about how you want to be treated if you get very sick.

This form has 3 parts. It lets you:

- 1 Choose a medical decision-maker**
A medical decision-maker is a person who can make health care decisions for you if you are too sick to make them yourself.
- 2 Make your own health care choices**
This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.
- 3 Sign the form**
It must be signed before it can be used.

You can fill out **Part 1, Part 2, or both.**
Fill out **only** the parts you want. Always sign the form in Part 3. 2 witnesses need to sign on page 11.

Your Name: _____

Pennsylvania Advance Health Care Directive

- ▶ **If you only want to name a medical decision-maker:**
go to **Part 1** on **page 3**.
- ▶ **If you only want to make your own health care choices:**
go to **Part 2** on **page 6**.
- ▶ **If you want both:**
fill out **Part 1** and **Part 2**.

Always sign the form in Part 3 on page 9.
2 witnesses need to sign on page 11.

What if I change my mind?

- Fill out a new form.
- Tell those who care for you about your changes.
- Give the new form to your medical decision-maker and doctor.

What if I have questions about the form?

Ask your doctors, nurses, social workers, friends, or family to answer your questions. Lawyers can help too.

What if I want to make health care choices that are not on this form?

Write your choices on page 9.

Share this form and your choices with your family, friends, and medical providers.

Pennsylvania Advance Health Care Directive

PART 1

Choose your medical decision-maker

The person who can make health care decisions for you if you are too sick to make them yourself.

Whom should I choose to be my medical decision-maker?

A family member or friend who:

- Is at least 18 years old
- Knows you well
- Can be there for you when you need them
- You trust to do what is best for you
- Can tell your doctors about the decisions you made on this form

Your decision-maker **cannot** be your doctor or someone who works at your hospital or clinic, unless he/she is a family member.

What will happen if I do not choose a medical decision-maker?

If you are too sick to make your own decisions, a person will be chosen for you according to Pennsylvania law. This person may not know what you want.

What kinds of decisions can my medical decision-maker make?

Agree to, say no to, change, stop or choose:

- Doctors, nurses, social workers
- Hospitals, clinics, or where you live
- Medications, tests, or treatments
- What happens to your body and organs after you die

Your decision-maker will need to follow the health care choices you make in Part 2.

PART 1

Choose your medical decision-maker

Other decisions your medical decision-maker can make:

Life Support Treatments

Medical care to try to help you live longer

- **CPR or cardiopulmonary resuscitation**
 - (cardio = heart) (pulmonary = lungs) (resuscitation = to bring back)
 - This may involve:
 - Pressing hard on your chest to keep your blood pumping
 - Electrical shocks to jump-start your heart
 - Medicines in your veins
- **Breathing machine or ventilator**
 - The machine pumps air into your lungs and breathes for you. You are not able to talk when you are on the machine.
- **Dialysis**
 - A machine that cleans your blood if your kidneys stop working.
- **Feeding Tube**
 - A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.
- **Blood transfusions**
 - To put blood in your veins.
- **Surgery**
- **Medicines**

End of Life Care

If you might die soon your medical decision-maker can:

- Call in a spiritual leader
- Decide if you die at home or in the hospital
- Decide where you should be buried

Show your medical decision-maker this form.

Tell your decision maker what kind of medical care you want.

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PART 1

Your Medical Decision Maker

I want this person to make my medical decisions if I cannot make my own.

First Name

Last Name

Home Number

Work Number

Relationship

Street Address

City

State

Zip Code

If the first person cannot do it, then I want this person to make my medical decisions.
Also, if the first person is a spouse and you divorce, the doctors will turn to this person.

First Name

Last Name

Home Number

Work Number

Relationship

Street Address

City

State

Zip Code

Put an X next to the sentence you agree with:

- My medical decision-maker can make decisions for me right after I sign this form.
- My medical decision-maker will make decisions for me **only** after I cannot make my own decisions.

How do you want your medical decision maker to follow your healthcare wishes?

Put an X next to the one sentence you most agree with:

- Total Flexibility:** It is OK for my decision-maker to change any of my medical decisions if my doctors think it is best for me at that time.
- Some Flexibility:** It is OK for my decision-maker to change some of my decisions if the doctors think it is best. But, these are some wishes I never want changed:

-
- No Flexibility:** I want my decision maker to follow my medical wishes exactly, no matter what. It is not OK to change my decisions, even if the doctors recommend it.

To make your own health care choices, go to **Part 2** on the next page.
If you are done, you must sign this form on **page 9**.

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PART 2

Make your own health care choices

Write down your choices so those who care for you will not have to guess.

**Think about what makes your life worth living.
Put an X next to all the sentences you most agree with:**

My life is only worth living if I can:

- Talk to family or friends
- Wake up from a coma
- Feed, bathe, or take care of myself
- Be free from pain
- Live without being hooked up to machines
- My life is always worth living no matter how sick I am
- I am not sure

If I am dying, it is important for me to be:

- At home
- In the hospital
- I am not sure

Is religion or spirituality important to you?

- No
 - Yes
- If you have one, what is your religion?

What should your doctors know about your religious or spiritual beliefs?

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.

6 Your Name: _____

Pennsylvania Advance Health Care Directive

PART 2

Make your own health care choices

Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.

Please read this whole page before you make your choice.

Put an X next to the one choice you most agree with.

If I am so sick that I may die soon:

- Try all life support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, **I want to stay on life support machines** even if I am suffering.
- Try all life support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, **I do NOT want to stay on life support machines.** If I am suffering, I want to stop.
- I do not want life support treatments,** and I want to focus on being comfortable. I prefer to have a natural death.
- I want my **medical decision-maker** to decide for me.
- I am not sure.

***If you are pregnant and become unable to make decisions:**

Pennsylvania law may require your doctor to give you life support treatments even if you have an advance directive.

If you want to write down medical wishes that are not on this form, go to page 9.

Your Name: _____

Pennsylvania Advance Health Care Directive

PART 2

Make your own health care choices

Your doctors may ask about organ donation and autopsy after you die.
Please tell us your wishes.

Put an X next to the one choice you most agree with.

Donating (giving) your organs can help save lives.

I **want** to donate my organs.

Which organs do you want to donate?

Any organ

Only: _____

I **do not want** to donate my organs.

I want my **decision-maker** to decide.

I am not sure.

An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.

I **want** an autopsy.

I **do not want** an autopsy.

I **only** want an autopsy if there are questions about my death.

I want my **decision-maker** to decide.

I am not sure.

What should your doctors know about how you want your body to be treated after you die? Do you have funeral or burial wishes?

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PART 2

Make your own health care choices

What other wishes are important to you?

PART 3

Sign the form

Before this form can be used, you must:

- ✓ Sign this form if you are at least 18 years of age
- ✓ Have 2 witnesses sign the form

Sign your name and write the date.

_____/_____/_____
Sign your name Date

Print your first name Print your last name

Address City State Zip Code

Pennsylvania Advance Health Care Directive

PART 3

Witnesses

Before this form can be used you must have 2 witnesses sign the form

Your witnesses must:

- ✓ Be over 18 years of age
- ✓ Know you
- ✓ See you sign this form

Your witnesses cannot:

- Be your medical decision-maker
- Be your health care provider
- Work for your health care provider
- Work at the place that you live

Also, one witness cannot:

- Be related to you in any way
- Benefit financially (get any money or property) after you die

Witnesses need to sign their names on the next page.

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PART 3

Witnesses Signing

Have your witnesses sign their names and write the date

By signing, I promise that _____ signed this form while I watched.
(name)

He/she was thinking clearly and was not forced to sign it. I also promise that:

- I know this person and he/she could prove who he/she was
- I am 18 years or older
- I am not his/her medical decision-maker
- I am not his/her health care provider
- I do not work for his/her health care provider
- I do not work where he/she lives

One witness must also promise that:

- I am not related to him/her by blood, marriage, or adoption
- I will not benefit financially (get any money or property) after he/she dies

Witness #1

_____/_____/_____
Sign your name Date

Print your first name Print your last name

Address City State Zip Code

Witness #2

_____/_____/_____
Sign your name Date

Print your first name Print your last name

Address City State Zip Code



You are now done with this form.

**Share this form with your family,
friends, and medical providers.**

**Talk with them about your medical
wishes.**

UPMC
LIFE CHANGING MEDICINE

This advance directive is in compliance with the Pennsylvania Probate Code 20 PA. C.S.A. §§ 5421-5431.
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