AtlantiCare
REGIONAL MEDICAL CENTER

*122*

# ADVANCE DIRECTIVE FOR HEALTH CARE (LIVING WILL)

Patient Label

**Instructions:** Have your healthcare provider assist you when developing your Advance Directive. Keep the original at home where it can easily be found. Give copies of the completed form to your doctor(s), your family, your Healthcare Agent (Medical Representative), and anyone else who is likely to be contacted in a medical emergency. Review your Advance Directive form from time to time and make any needed changes. Initial and date the form every time you review or change it. Make sure you inform others of the changes you make.

To my Family, Doctors and others concerned with my care:

I,_____ , being of sound mind, hereby declare and make known my instructions and wishes for future health care in the event that, for reasons due to physical or mental incapacity, I am unable to participate in decisions regarding my care. I understand that the law gives me the right to accept or refuse treatment. Therefore, I expect my family, doctors and everyone concerned with my care to regard themselves as legally bound to follow these instructions. If they do, everyone will be free of any legal liability for having followed my directions.

**Healthcare Agent (also referred to as Medical Representative or Proxy) Designations(s): If I become unable to communicate my wishes due to illness, injury, or unconsciousness, the following individuals are hereby appointed and may make decisions on my behalf, and the hospital, its employees and physicians may rely and follow the instructions of these representatives.**

| Name | Relationship | | Telephone |
|---|---|---|---|
| Street | City | State | Zip |

**If my healthcare agent listed above is unable to act, then I appoint as alternate:**

| Name | Relationship | | Telephone |
|---|---|---|---|
| Street | City | State | Zip |

**I understand that I will be kept comfortable and provided appropriate medical care that aligns with the choice I select below. Please initial the statement with which you agree. (Select and initial #1 or #2.)**

_____ 1. I direct that all medically appropriate measures be provided to sustain my life, regardless of my physical condition or my chance to recover the ability to know who I am or who I am with.

_____ 2. If there is no reasonable expectation that I will regain a meaningful quality of life or recover the ability to know who I am or who I am with, then life prolonging measures should not be initiated. If life-sustaining measures have already been initiated, they should be discontinued.

I define a meaningful quality of life as

_____

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Additional comments or instructions:

After death, it may be possible to transplant human organs or tissues in order to save or improve the lives of others.

☐ I wish to be an organ donor:
☐ I wish to be a tissue donor:
☐ I am not interested in being an organ and/or tissue donor
☐ I have not fully considered organ and/or tissue donation and empower my family or Medical Representative to use their discretion in this matter

Signature Date Time

Address:_____ State:_____ Zip:_____

Date of Birth:_____

Witness Telephone Date

Witness Telephone Date