Florida Advance Directives:

Living Will, Healthcare Surrogate & Mental Health Advance Directive

FAQ & Template Forms

Penny Nova

Smashwords Edition

This ebook contains the Advance Healthcare Directives in the state of Florida, specifically a Living Will template, Healthcare Surrogate form, Mental Health Advance Directive & FAQ. The Living Will, Healthcare Surrogate form and FAQ are offered courtesy of the Florida Bar and Florida Medical Associations. The Mental Health Advance Directive is provided courtesy of the Florida Department of Children & Families.

To print out or download PDF or Word formats of these documents, please go to:

http://www.paperwell.com/docs/9-florida-living-will

http://www.paperwell.com/docs/476-florida-designation-of-healthcare-surrogate

http://www.paperwell.com/docs/477-florida-mental-health-advance-directive

Supplemental information may be found here:
http://archive.flsenate.gov/welcome/living_will/EOL.pdf &
http://www.dcf.state.fl.us/programs/samh/mentalhealth/laws/

NOTE: Nothing in this ebook should be considered legal advice, and no attorney-client relationship is formed by your use of this ebook. This information may not be suited for your specific situation. Please consult an attorney to address your particular needs.

LIVING WILLS AND HEALTH CARE ADVANCE DIRECTIVES: FAQs

The Florida Legislature has recognized that every competent adult has the fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment or procedures which would only prolong life when a terminal condition exists. This right, however, is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession. To ensure that this right is not lost or diminished by virtue of later physical or mental incapacity, the Legislature has established a procedure within Florida Statutes Chapter 765 allowing a person to plan for incapacity, and if desired, to designate another person to act on his or her behalf and make necessary medical decisions upon such incapacity.

What is a Living Will?

Every competent adult has the right to make a written declaration commonly known as a "Living Will." The purpose of this document is to direct the provision, the withholding or withdrawal of life prolonging procedures in the event one should have a terminal condition. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.303. In Florida, the definition of "life prolonging procedures" has been expanded by the Legislature to include the provision of food and water to terminally ill patients.

What is the difference between a Living Will and a legal will?

A Living Will should not be confused with a person's legal will, which disposes of personal property on or after his or her death, and appoints a personal representative or revokes or revises another will.

How do I make my Living Will effective?

Under Florida law, a Living Will must be signed by its maker in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. If the maker is physically unable to sign the Living Will, one of the witnesses can sign in the presence and at the direction of the maker. Florida will recognize a Living Will, which has been signed in another state, if that Living Will was signed in compliance with the laws of that state, or in compliance with the laws of Florida.

After I sign a Living Will, what is next?

Once a Living Will has been signed, it is the maker's responsibility to provide notification to the physician of its existence. It is a good idea to provide a copy of the Living Will to the maker's physician and hospital, to be placed within the medical records.

What is a Health Care Surrogate?

Any competent adult may also designate authority to a Health Care Surrogate to make all health care decisions during any period of incapacity. During the maker's incapacity, the Health Care Surrogate has the duty to consult expeditiously, with appropriate health care providers. The Surrogate also provides informed consent and makes only health care decisions for the maker, which he or she believes the maker would have made under the circumstances if the maker were capable of making such decisions. If there is no indication of what the maker would have chosen, the Surrogate may consider the maker's best interest in deciding on a course of treatment. The suggested form of this instrument has been provided by the Legislature within Florida Statutes Section 765.203.

How do I designate a Health Care Surrogate?

Under Florida law, designation of a Health Care Surrogate should be made through a written document, and should be signed in the presence of two witnesses, at least one of whom is neither the spouse nor a blood relative of the maker. The person designated as Surrogate cannot act as a witness to the signing of the document.

Can I have more than one Health Care Surrogate?

The maker can also explicitly designate an Alternate Surrogate. The Alternate Surrogate may assume the duties as Surrogate if the original Surrogate is unwilling or unable to perform his or her duties. If the maker is physically unable to sign the designation, he or she may, in the presence of witnesses, direct that another person sign the document. An exact copy of the designation must be provided to the Health Care Surrogate. Unless the designation states a time of termination, the designation will remain in effect until revoked by its maker.

Can the Living Will and the Health Care Surrogate designation be revoked?

Both the Living Will and the Designation of Health Care Surrogate may be revoked by the maker at any time by a signed and dated letter of revocation; by physically canceling or destroying the original document; by an oral expression of one's intent to revoke; or by means of a later executed document which is materially different from the former document. It is very important to tell the attending physician that the Living Will and Designation of Health Care Surrogate has been revoked.

Where can I go to obtain legal advice on this issue?

If you believe you need legal advice, call your attorney. If you do not have an attorney, call The Florida Bar Lawyer Referral Service at 1-800-342-8011, or the local lawyer referral service or legal aid office listed in the yellow pages of your telephone book.

This information has been prepared by the Consumer Protection Law Committee of The Florida Bar and the Bar's Public Information Office and is offered as a courtesy of The Florida Bar and the Florida Medical Association.

Suggested form of a Living Will, Florida Statutes Section 765.303

A living will may, BUT NEED NOT, be in the following form:

Living Will

Declaration made this _____ day of _____ 2_____, 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 attending or treating 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 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 _____
City _____ State _____ Zip _____
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 _____
Street Address _____
City, State& Zip _____
Phone _____

Witness _____
Street Address _____
City, State& Zip _____
Phone _____

The principal's failure to designate a surrogate shall not invalidate the living will.

— This form offered as a courtesy of The Florida Bar and the Florida Medical Association —

Suggested form of a Health Care Surrogate, Florida Statutes Section 765.203

Designation of Health Care Surrogate

Name _____

In the event I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate, as my surrogate for health care decisions:

Name _____

Street Address _____

City _____ State _____ Zip _____

Phone _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name _____

Street Address _____

City _____ State _____ Zip _____

Phone _____

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

Additional Instructions (optional): _____

I further affirm that this designation is not being made as a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name _____
Name _____

Signed: _____

Witnesses

1. _____
2. _____

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

— This form offered as a courtesy of The Florida Bar and the Florida Medical Association —

Mental Health Advance Directive

If you believe you may be hospitalized for mental health care in the future and that your doctor may think you aren't able to make good decisions about your treatment, completion of a mental health advance directive will help make your treatment preferences known. It is important that you decide NOW what types of treatment you do or do not want and to appoint a friend or family member to make the mental health care decisions that you want carried out.

- You can use the following advance directive form to direct your future care.
- Read each section of the form carefully and talk about your choices with your case manager, doctor, or other trusted persons.
- The person you choose to be your health care surrogate and alternate must be a competent person who is at least 18 years old, whose civil rights have not been taken away. The person you choose should not be a mental health professional, an employee of a facility which might provide services to you, an employee of the Department of Children & Family Services, or a member of the Local Advocacy Council.
- Make sure your surrogate understands your wishes and is willing to take the responsibility.
- You and your surrogate (and a back-up alternate surrogate if you wish) should sign the form in front of two witnesses.
- Have copies made and give them to your surrogate, your case manager, your doctor, the hospital or crisis unit at which you are most likely be taken, your family, and anyone else who might be involved in your care. Discuss your choices with each of them.

You can change your advance directive at anytime you are competent to do so. If you travel, be sure to take a copy of the advance directive with you. Your advance directive will not take effect unless a physician decides that you are incompetent to make your own treatment decisions. If you are in a psychiatric facility, you will have an attorney appointed to represent your interests, and will have a hearing in front of a judge or hearing master. A health care surrogate is not authorized to consent to treatment for a person on voluntary status.

I, _____ , being ofsound mind, willfully and voluntarily execute this mental health advance directive to assure that if I should be found incompetent to consent to my own mental health treatment, my choices regarding my treatment will be carried out despite my inability to make informed decisions for myself.

If a guardian or other decision-maker is appointed by a court to make health care or mental health decisions for me, I intend this document to take precedence over all other means of determining my intent while competent. This document represents my wishes and it should be given the greatest possible legal weight and respect. If the surrogate(s) named in this directive are not available, my wishes shall be binding on whoever is appointed to make such decisions.

If I become incompetent to make decisions about my own mental health treatment, I have authorized a mental health care surrogate to make certain treatment decisions for me. My surrogate is also authorized to apply for public benefits to defray the cost of my health care, to release information to appropriate persons, and to authorize my transfer from a health care facility.

My mental health care surrogate is:

Name: _____
Address: _____
Day Telephone: _____ Evening Telephone: _____

I, _____ , mental health care surrogate designated by _____ hereby accept the designation.
_____ (Signature of Mental Health Care Surrogate)
_____ (Date)

If the person named above is unavailable or unable to serve as my mental health care surrogate, I hereby appoint and want immediate notification of my alternate mental health care surrogate as follows:

Name of Alternate: _____
Address: _____
Day Telephone: _____ Evening Telephone: _____

I, _____ , alternate mental health care surrogate designated by _____ hereby accept the designation.
_____ (Signature of Alternate Mental Health Care Surrogate)
_____ (Date)

Complete the following or Initial in the blank marked yes or no:

A. If I become incompetent to give consent to mental health treatment, I give my mental health care surrogate full power and authority to make mental health care decisions for me. This includes the right to consent, refuse consent, or withdraw consent to any mental health care, treatment, service, or procedure, consistent with any instructions and/or limitations I have stated in this advance directive. If I have not expressed a choice in this advance directive, I authorize my surrogate to make the decision my surrogate determines is the decision I would make if I were competent to do so. _____ Yes _____ No
B. My choice of treatment facilities are as follows:

1. In the event my psychiatric condition is serious enough to require 24-hour care, I would prefer to receive this care in this/these facilities:

   Facility: _____

   Facility: _____

2. I do not wish to be placed in the following facilities for psychiatric care for the reasons I have listed:

   Facility/ Reason: _____

   Facility/ Reason: _____

C. My choice of a treating physician is:

   First choice of physician: _____

   Second choice of physician: _____

   I do not wish to be treated by the following physicians:

   Name of physician: _____

   Name of physician: _____

D. My wishes regarding confidentiality of my admission to a facility and my treatment while there are as follows:
   1. _____My representative may be notified of my involuntary admission

      ___Yes ___No

   2. _____Any person who seeks to contact me while I am in a facility may be told I am there. ___Yes ___No
   3. _____I consent to release of information about my condition and treatment plan ___Yes ___No

      To the following persons:

      _____

      _____

_____

4. _____I do not consent to the release of information about my admission or treatment to anyone unless I give specific consent at the time of the request or as otherwise allowed by law. ___Yes ___No

E. If I am not competent to consent to my own treatment or to refuse medications relating to my mental health treatment, I have initialed one of the following, which represents my wishes:
   1. _____ I consent to the medications that Dr. _____ recommends.
   2. _____ I consent to the medications agreed to by my mental health care surrogate, after consulting with my treating physician and any other individuals my surrogate may think appropriate, with the exceptions found in #3 below.
   3. _____ I specifically do not consent and I do not authorize my mental health care surrogate to consent to the administration of the following medications or their respective brand name, trade name, or generic equivalents: (list name of drug and reason for refusal)

      _____

      _____

      _____

   4. _____ I am willing to take the medications excluded in #3 above if my only reason for excluding them is their side effects and the dosage can be adjusted to eliminate those side effects.
   5. I have the following other preferences about psychiatric medications:

      _____

      _____

      _____

F. My wishes regarding Electroconvulsive Therapy (ECT) are as follows:
   1. _____ My surrogate may not consent to ECT without express court approval.
   2. _____ I authorize my surrogate to consent to ECT.
   3. Other instructions and wishes regarding ECT are as follows:

      _____

      _____

_____

G. If, during a stay in a psychiatric facility, my behavior requires an emergency intervention, my wishes regarding which form of emergency interventions should be made in the following order: (fill in numbers, giving 1 to your first choice, 2 to your second, and so on until each has a number). If an intervention you prefer is not listed, write it in after "other" and give it a number.

___ Medication in pill form

___ Medication in liquid medication

___ Medication by injection

___ Seclusion

___ Physical restraints

___ Both seclusion and physical restraints

___ Other:

_____

_____

_____

H. Florida law prohibits a mental health care surrogate from consenting to experimental treatments that have not been approved by a federally approved institutional review board without my prior written consent or the express approval of the court.

_____ I consent to my participation in experimental drug studies or drug trials

_____ I do not wish to participate in experimental drug studies or drug trials

I. If I am incompetent to give consent, I want staff to immediately notify the following persons that I have been admitted to a psychiatric facility.

Name: _____
Relationship: _____
Address: _____

Day Telephone: _____ Evening Telephone: _____

Name: _____
Relationship: _____
Address: _____
Day Telephone: _____ Evening Telephone: _____

J. Other instructions I wish to make about my mental health care are (use additional pages if needed):

_____

_____

_____

By signing here I indicate that I fully understand that this advance directive will permit my mental health care surrogate to make decisions and to provide, withhold, or withdraw consent for my mental health treatment.

Printed Name (Declarant): _____

Signature: _____ Date: _____

This advance directive was signed by _____ in our presence. At his/her request, we have signed our names below as witness. We declare that, at the time this advance directive was signed, the Declarant, according to our best knowledge and belief was of sound mind and under no constraint or undue influence. We further declare that we are both adults, are not designated in this advance directive as the mental health care surrogate, and at least one of us is neither the person's spouse nor blood relative.

Dated at _____ (County & State), this _____ day of _____ (Month), _____ (Year).

Witness Signatures:

Witness 1:

Signature of witness 1 _____

Printed name of witness 1 _____

Home address of witness 1 _____

City, State, Zip Code of witness 1 _____

Witness 2:

Signature of witness 2 _____

Printed name of witness 2 _____

Home address of witness 2 _____

City, State, Zip Code of witness 2 _____

Baker Act Handbook and User Reference Guide / 2002

State of Florida Department of Children & Families