An Advance Directive For North Carolina

A Practical Form for All Adults

Introduction

This form allows you to express your wishes for future health care and to guide decisions about that care. It does not address financial decisions. Although there is no legal requirement for you to have an advance directive, completing this form may help you to receive the health care you desire.

If you are 18 years old or older and are able to make and communicate health care decisions, you may use this form.

This form has three parts. You may complete Part A only, or Part B only, or both Parts A and B. To make this advance directive legally effective, you must complete Part C of this form. Please keep all five pages of this form together and include all five pages of the form in any copies you may share with your loved ones or health care providers.

This form complies with North Carolina law (in NCGS § 32A-15 through 32A-27 and § 90-320 through 90-322).

Part A: Health Care Power of Attorney

- **1. What is a health care power of attorney?** A health care power of attorney is a legal document in which you name another person, called a "health care agent," to make health care decisions for you when you are not able to make those decisions for yourself.
- **2. Who can be a health care agent?** Any competent person who is at least 18 years old and who is not your paid health care provider may be your health care agent.
- **3. How should you choose your health care agent?** You should choose your health care agent very carefully, because that person will have broad authority to make decisions about your health care. A good health care agent is someone who knows you well, is available to represent you when needed, and is willing to honor your wishes. It is very important to talk with your health care agent about your goals and wishes for your future health care, so that he or she will know what care you want.
- **4. What decisions can your health care agent make?** Unless you limit the power of your health care agent in Section 2 of Part A of this form, your health care agent can make <u>all</u> health care decisions for you, including:
 - starting or stopping life-prolonging measures
 - decisions about mental health treatment
 - choosing your doctors and facilities
 - reviewing and sharing your medical information
 - autopsies and disposition of your body after death
- **5. Can your health care agent donate your organs and tissues after your death?** Yes, if you choose to give your health care agent this power on the form. To do this, you must initial the statement in Section 3 of Part A.
- **6. When will this health care power of attorney be effective?** This document will become effective if your doctor determines that you have lost the ability to make your own health care decisions.

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- **7. How can you revoke this health care power of attorney?** If you are competent, you may revoke this health care power of attorney in any way that makes clear your desire to revoke it. For example, you may destroy this document, write "void" across this document, tell your doctor that you are revoking the document, or complete a new health care power of attorney.
- 8. Who makes health care decisions for me if I don't name a health care agent and I am not able to make my own decisions? If you do not have a health care agent, NC law requires health care providers to look to the following individuals, in the order listed below: legal guardian; an attorney-in-fact under a general power of attorney (POA) if that POA includes the right to make health care decisions; a husband or wife; a majority of your parents and adult children; a majority of your adult brothers and sisters; or an individual who has an established relationship with you, who is acting in good faith and who can convey your wishes. If there is no one, the law allows your doctor to make decisions for you as long as another doctor agrees with those decisions.

Part B: Living Will

- **1. What is a living will?** In North Carolina, a living will lets you state your desire not to receive life-prolonging measures in any or all of the following situations:
 - You have a condition that is incurable that will result in your death within a short period of time.
 - You are unconscious, and your doctors are confident that you cannot regain consciousness.
 - You have advanced dementia or other substantial and irreversible loss of mental function.
- **2. What are life-prolonging measures?** Life-prolonging measures are medical treatments that would only serve to postpone death, including breathing machines, kidney dialysis, antibiotics, tube feeding (artificial nutrition and hydration), and similar forms of treatment.
- **3. Can life-prolonging measures be withheld or stopped without a living will?** Yes, in certain circumstances. If you are able to express your wishes, you may refuse life-prolonging measures. If you are not able to express your wishes, then permission must be obtained from those individuals who are making decisions on your behalf.
- **4. What if you want to receive tube feeding (artificial nutrition and hydration)?** You may express your wish to receive tube feeding in all circumstances. To do this, you must initial the statement in Section 2 of Part B.
- **5. How can you revoke this living will?** You may revoke this living will by clearly stating or writing in any clear manner that you wish to do so. For example, you may destroy the document, write "void" across the document, tell your doctor that you are revoking the document, or complete a new living will.

Part C: Completing this Document

To make this advance directive legally effective, all three sections of Part C of the document must be completed.

- **1.** Wait until two witnesses and a notary public are present, then sign and date the document.
- **2.** Two witnesses must sign and date the document in Section 2 of Part C. These witnesses cannot be:
 - related to you by blood or marriage,
 - your heir, or a person named to receive a portion of your estate in your will,
 - someone who has a claim against you or against your estate, or
 - your doctor, other health care provider, or an employee of a hospital in which you are a patient, or an employee of the nursing home or adult care home where you live.

 $\textbf{3.} \ \ \textbf{A notary public must witness these signatures and notarize the document in Section 3 of Part C.}$

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Part A: Health Care Power of Attorney (Choosing a Health Care Agent)

1. The person I choose as my health care agent is: First name	My name is:	(Please Print)	My	birth date is://
first name middle name last name street address city state zip code home phone work phone cell phone e-mail address If this person is unable or unwilling to serve as my health care agent, my next choice is: first name middle name last name street address city state zip code home phone work phone cell phone e-mail address 2. Special Instructions: NOTE: In this section, you may include any special instructions you want your health care agen or any limitations you want to put on the decisions your health care agent can make, including d about tube feeding, other life-prolonging treatments, mental health treatments, autopsy, dispositibody after death, and organ donation. If you do not have any special instructions for your health care agent, or any limitations yo		(Flease Fillit)		
street address city state zip code home phone work phone cell phone e-mail address If this person is unable or unwilling to serve as my health care agent, my next choice is: first name middle name last name street address city state zip code home phone work phone cell phone e-mail address 2. Special Instructions: NOTE: In this section, you may include any special instructions you want your health care agen or any limitations you want to put on the decisions your health care agent can make, including d about tube feeding, other life-prolonging treatments, mental health treatments, autopsy, disposition body after death, and organ donation. If you do not have any special instructions for your health care agent, or any limitations yo	1. The person I	choose as my health care	agent is:	
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NOTE: In this section, you may include any special instructions you want your health care agen or any limitations you want to put on the decisions your health care agent can make, including d about tube feeding, other life-prolonging treatments, mental health treatments, autopsy, dispositi body after death, and organ donation. If you do not have any special instructions for your health care agent, or any limitations yo	2. Special Instru	actions:		
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	3. Organ Donati	ion:		
3. Organ Donation:	(initial) My	health care agent may don	ate my organs, tissues, o	r parts after my death.
3. Organ Donation:(initial) My health care agent may donate my organs, tissues, or parts after my death.	(Please note: if vou	do not initial above, your hea	alth care agent will not be a	able to donate your organs or p

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Part B: Living Will

If you do not wish to	prepare a living will, strike	through this entire part and initial here
My name is:		My birth date is://
	(Please Print)	
		ealth care decisions, I desire that my life not be e following situations (you may initial any or all of these
(initial)	I have a condition that can relatively short period of	not be cured and that will result in my death within a time.
(initial)	I become unconscious and certainty, I will never rega	my doctors determine that, to a high degree of medical ain my consciousness.
(initial)		nentia or any other condition which results in the ity to think, and my doctors determine that, to a high degree s not going to get better.
the situations I have	_	ny life prolonged by other life-prolonging measures in ove, <u>IDO</u> want to receive tube feeding in those situations those situations).
	-	ole. I want my health care providers to keep me as clean, nough this care may hasten my death.
-	oviders may rely on this nations I have initialed ab	living will to withhold or discontinue life-prolonging oove.
and that health care	_	Part A of this advance directive or a similar document, that differ from the desires expressed in this living will, ces below):
(initial)	•	My health care agent cannot make decisions that are re stated in this living will.
(initial)	_	t: My health care agent has the authority to make decisions hat I have indicated in this living will.

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Part C: Completing this Document (wait until two witnesses and a notary public are present before you sign!)

1. Your Signature

I am mentally alert and co	ompetent, and I am fully in	nformed about the contents of thi	s document.
Date:			
Signature:			
2. Signatures of Witnes	sses		
directed another to sign person by blood or mark existing will or codicil on the person's attendiwho is (1) an employee of the health facility in v	on the person's behalf) the riage, and I would not be end f the person or as an heir un ng physician. I am not a lice of the person's attending phyhich the person is a patient	, being of some foregoing document in my presence titled to any portion of the estate of the der the law, if the person died on the ensed health care provider or mental hysician or mental health treatment person (3) an employee of a nursing horegainst the person or the estate of the	. I am not related to the the person under any is date without a will. I am health treatment provider provider, (2) an employee me or any adult care home
Date:	Signature of Witne	ess:	
Date:	Signature of Witne	ess:	
3. Notarization			
	COUNTY,	STATE	
Sworn to (or affirmed) an	nd subscribed before me tl	his day by	
		(type/print name of signer)	
		(type/print name of witness	3)
		(type/print name of witness	·)
Date: (Official Seal)		ignature of Notary Public	
(O)) total Douly			_, Notary Public
		rinted or typed name	_, ivotal y Fublic
	My commission	n expires:	

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