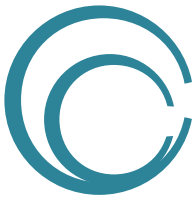

compassion & choices

Care & Choices at the End of Life.

Advance Directive

Planning for Important Healthcare Decisions

Delaware

Delaware Advance Healthcare Directive

EXPLANATION

You have the right to give instructions about your own healthcare. You also have the right to name someone else to make healthcare decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding anatomical gifts and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

****

SECTION I: POWER OF ATTORNEY FOR HEALTHCARE

(1) DESIGNATION OF AGENT: I designate the following person as my agent to make healthcare decisions for me:

_____
(name of agent)

_____
(address)

_____
(city, state, zip code)

_____
(home phone, work phone)

If I revoke the authority of my agent or if my agent is not willing, able, or reasonably available to make healthcare decisions for me, I designate as my first alternate agent:

_____
(name of first alternative agent)

_____
(address)

_____
(city, state, zip code)

_____
(home phone, work phone)

(Continued)

If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a healthcare decision for me, I designate as my second alternate:

_____
(name of second alternative agent)

_____
(address)

_____
(city, state, zip code)

_____
(home phone, work phone)

(2) AGENT'S AUTHORITY: If I do not have a qualifying condition my agent is authorized to make all healthcare decisions for me, except decisions about life-sustaining procedures and as I state here:

and if I have a qualifying condition, my agent is authorized to make all healthcare decisions for me, except as I state here:

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I lack the capacity to make my own healthcare decisions. As to decisions concerning providing, withholding and withdrawal of life-sustaining procedures, my agent's authority becomes effective when my primary physician determines I lack the capacity to make my own healthcare decisions and my primary physician and another physician determine I am in a terminal condition or permanently unconscious.

(Continued)

(4) AGENT'S OBLIGATION: My agent shall make healthcare decisions for me in accordance with this power of attorney for healthcare, any instructions I give in Section II of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make healthcare decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court:

☐ I nominate the agent(s) whom I named in this form in the order designated to act as guardian.

☐ I nominate the following to be guardians in the order designated:

_____

_____

☐ I do not nominate anyone to be guardian.

(Continued)

SECTION II: INSTRUCTIONS FOR HEALTHCARE

(6) END-OF-LIFE DECISIONS: If I can no longer make my own decisions and I have a qualifying condition, I direct that my healthcare providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

A. Choice To Prolong Life:

☐ **I want my life to be prolonged as long as possible within the limits of generally accepted healthcare standards.**

B. Choice NOT To Prolong Life:

☐ **I do not want my life to be prolonged if I have a terminal condition** (an incurable condition caused by injury, disease or illness which to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life-sustaining procedures, there can be no recovery.)

I make the following instructions regarding artificial nutrition and hydration if I have a terminal condition:

Artificial **Nutrition** ☐ I want ☐ I do not want

Artificial **Hydration** ☐ I want ☐ I do not want

☐ **I do not want my life to be prolonged if I become permanently unconscious** (a medical condition that has been diagnosed in accordance with currently accepted medical standards that has lasted at least 4 weeks and with reasonable medical certainty as total irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma.)

(Continued)

I make the following instructions regarding artificial nutrition and hydration if I become permanently unconscious:

Artificial **Nutrition** ☐ I want ☐ I do not want

Artificial **Hydration** ☐ I want ☐ I do not want

(7) RELIEF FROM PAIN OR DISCOMFORT: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death.

(8) OTHER HEALTHCARE INSTRUCTIONS OR WISHES:
(add additional pages if needed)

SECTION III: DESIGNATION OF PRIMARY PHYSICIAN

(9) I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address)

_____
(city, state, zip code)

_____
(phone)

(Continued)

SECTION IV: ANATOMICAL GIFTS AT DEATH

(10) I am mentally competent and 18 years or more of age.

I hereby make this anatomical gift to take effect upon my death. The marks in the appropriate lines and words filled into the blank indicate my desires.

I give:

- ☐ My body
- ☐ any needed organs or parts
- ☐ the following organ or parts: _____

To the following person or institutions:

- ☐ the physician in attendance at my death
- ☐ the hospital at which I die
- ☐ the following named physician, hospital storage bank or medical institution:

  _____
- ☐ the following individual for treatment _____

For the following purposes:

- ☐ any purpose authorized by law
- ☐ transplantation
- ☐ therapy
- ☐ research
- ☐ medical education

(11) EFFECT OF A COPY : A copy of this form has the same effect as the original.

(Continued)

(12) SIGNATURE OF DECLARANT

_____
(name)

_____
(address)

_____
(date)

_____
(signature)

(13) STATEMENT OF WITNESSES

SIGNED AND DECLARED by the above named-declarant as and for his/her written declaration under 16 Del.C. §§2502,2503, in our presence, who in his/her presence, at his/her request, and in the presence of each other, have hereunto subscribed our names as witnesses and state:

A. That the declarant is mentally competent.

B. That neither of us:

1. Is related to the declarant by blood, marriage or adoption;
2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of executing of the advance healthcare directive, is so entitled by operation of law then existing;
3. Has, at the time of the execution of the advance directive, a present or inchoate claim against any portion of the estate of the declarant;
4. Has direct financial responsibility for the declarant's medical care;
5. Has a controlling interest in or is an operator or employee of a residential long-term healthcare institution in which the declarant is a resident; or
6. Is under eighteen years of age

(Continued)

C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses_____, is at the time of the execution of the advance healthcare directive a patient advocate or ombudsman designated by the Division of Services for Aging Adults with Physical Disabilities or Public Guardian.

Signature of First Witness

_____
(name of first witness)

_____
(address of first witness)

_____
(signature of first witness)

_____
(date)

Signature of Second Witness

_____
(name of second witness)

_____
(address of second witness)

_____
(signature of second witness)

_____
(date)

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