Utah Advance Health Care Directive

(Pursuant to Utah Code Section 75-2a-117)

Part I: Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself.
Part II: Allows you to record your wishes about health care in writing.
Part III: Tells you how to revoke the form.
Part IV: Makes your directive legal.

My Personal Information

Name: _____
Street Address: _____
City, State, Zip: _____
Telephone: _____ Cell Phone: _____
Birth date: _____

Part I: My Agent

A. No Agent

_____ I do not want to choose an agent. Initial this paragraph if you do not want to name an agent, then go to Part II. Do not name an agent below. No individual, organization, family member, health care provider, lawyer, or insurer should force you to name an agent.

B. My Agent

Agent's Name: _____
Street Address: _____
City, State, Zip: _____
Telephone: _____ Cell Phone: _____
Work Phone: _____

C. Alternate Agent

Alternate Agent's Name: _____
Street Address: _____
City, State, Zip: _____
Telephone: _____ Cell Phone: _____
Work Phone: _____

D. Agent's Authority

If I cannot make decisions or speak for myself, my agent can make any health care decision I could have made such as:

1. Consent to, refuse, or withdraw any health care. This may include care to prolong my life such as food and fluids by tube, use of antibiotics, CPR (cardiopulmonary resuscitation), and dialysis, and mental health care, such as convulsive therapy and psychoactive medications. This authority is subject to any limits in paragraph F of this section or in Part II of this directive.
2. Hire and fire health care providers.
3. Ask questions and get answers from health care providers.
4. Consent to admission or transfer to a health care provider or health care facility, including a mental health facility, subject to any limits in paragraphs E or F of this section.
5. Get copies of my medical records.
6. Ask for consultations or second opinions.

E. Other Authority

My agent has the powers below ONLY IF I place a check next to "yes" in the statement. I authorize my agent to:
Yes ☐ No ☐ Get copies of my medical records at any time, even when I can speak for myself.
Yes ☐ No ☐ Admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other congregate facility for long-term placement other than convalescent or recuperative care, unless I agree to be admitted at that time.

F. I wish to limit or expand the powers of my healthcare agent as follows:

G. Nomination of Guardian

Yes ☐ No ☐ By appointing an agent in this document, I intend to avoid guardianship. If I must have a guardian, I want my agent to be my guardian.

H. Consent to Participate in Medical Research

Yes ☐ No ☐ I authorize my agent to consent to my participation in medical research or clinical trials, even if I may not benefit from the results.

I. Consent to Organ Donation

Yes ☐ No ☐ If I have not otherwise agreed to organ donation, my agent may consent to the donation of my organs for the purpose of organ transplantation.

J. Agent's Authority to Override Expressed Wishes

Yes ☐ No ☐ My agent may make decisions about health care that are different from the instructions in Part II of this form.

Part II: My Health Care Wishes (Living Will)

I want my health care providers to follow the instructions I give them when I am being treated, so long as I can make health care decisions, even if the instructions appear to conflict with these or other advance directives. My health care providers should always provide comfort measures and health care to keep me as comfortable and functional as possible.

Choose one of the following by placing your initials before the numbered statement that reflects your wishes.

1. _____ I choose to let my agent decide. I have chosen my agent carefully. I have talked with my agent about my health care wishes. I trust my agent to make the health care decisions for me that I would make under the circumstances. My agent may stop care that is prolonging my life only after the conditions checked "yes" below are met.

Yes ☐ No ☐ I have a progressive illness that will cause death.
Yes ☐ No ☐ I am close to death and am unlikely to recover.
Yes ☐ No ☐ I cannot communicate and it is unlikely that my condition will improve.
Yes ☐ No ☐ I do not recognize my friends or family and it is unlikely that my condition will improve.
Yes ☐ No ☐ I am in a persistent vegetative state.

2. _____ I want to prolong life. Regardless of my condition or prognosis, I want my health care providers to try to keep me alive as long as possible, within the limits of generally accepted health care standards.

3. _____ I choose NOT to receive care for the purpose of prolonging life, including food and fluids by tube, antibiotics, CPR, or dialysis used to prolong my life. I always want comfort care and routine medical care that will keep me as comfortable and functional as possible, even if that care may prolong my life. My health care provider may stop care that is prolonging my life only after the conditions checked "yes" below are met. If I check "no" to all the conditions, my health care provider should not provide care to prolong my life.

Yes ☐ No ☐ I have a progressive illness that will cause death.
Yes ☐ No ☐ I am close to death and am unlikely to recover.
Yes ☐ No ☐ I cannot communicate and it is unlikely that my condition will improve.
Yes ☐ No ☐ I do not recognize my friends or family and it is unlikely that my condition will improve.
Yes ☐ No ☐ I am in a persistent vegetative state.

4. _____ I choose not to provide instructions about end-of-life care in this directive.

Additional or Other Instructions: _____

_____

Part III: Revoking My Directive

I may revoke this directive by:
1. Writing "void" across the form, or burning, tearing, or otherwise destroying or defacing the document or asking another person to do the same on my behalf;
2. Signing or directing another person to sign a written revocation on my behalf;
3. Stating that I wish to revoke the directive in the presence of a witness who meets the requirements of the witness in Part IV, below, and who will not be appointed as agent or become a default surrogate when the directive is revoked; or
4. Signing a new directive. (If you sign more than one Advance Health Care Directive, the most recent one applies.)

Part IV: Making My Directive Legal

I sign this voluntarily. I understand the choices I have made. I declare that I am emotionally and mentally able to make this directive.

Date: _____
Signature: _____

I have witnessed the signing of this directive, I am 18 years of age or older, and I am not:
1. related to the declarant by blood or marriage;
2. entitled to any portion of the declarant's estate according to the laws of intestate succession of Utah or under any will or codicil of the declarant;
3. directly financially responsible for the declarant's medical care;

4. a health care provider who is providing care to the declarant or an administrator at a health care facility in which the declarant is receiving care; or
5. the appointed agent or alternate agent.

Signature of Witness:

_____

If the witness is signing to confirm an oral directive, describe below the circumstances under which the directive was made.

_____