Advance Care Plan Document

Property of:

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PROJECT GRACE

Project GRACE is a 501(c)3 non-profit organization. The mission of Project GRACE is to:

- ***Empower*** **individuals to communicate and implement their specific end-of-life medical treatment decisions.**
- ***Promote*** **the belief that all persons are entitled to humane and dignified end-of-life care in keeping with their personal wishes, values and spiritual beliefs.**
- ***Educate*** **professionals and the community about effective advance care planning to ensure that end-of-life healthcare choices are honored.**

Advance Care Plan Document

- Every competent American adult has the legal right to control his or her own health care decisions and to accept or refuse any medical treatment. An Advance Care Plan is a legal document that allows me to make my choices known in advance for receiving medical treatment if I should later become unable to express my choices for health care treatment.
- These will be followed **ONLY** when I have an illness or condition listed within this document.
- If you request that resuscitation (CPR) not be attempted outside the hospital, Florida requires a special form (DH Form 1896). Check with your state to find out if special forms are required in your state.

Illness/Conditions (from which there is little or no reasonable chance of recovery):

Use the following list as a reference when answering the questions on the next page.

- **End Stage Disease:** I have progressed toward final stages of life in spite of full treatment, or my vital organs are damaged beyond adequate function and cannot be replaced with transplantation (examples are widespread cancer that cannot be helped with treatment or severely damaged heart or lungs that causes a feeling of severe suffocation with any activity, despite oxygen treatment).
- **Unconscious State (Permanent Vegetative State):** I have been, and continue to be totally unaware with no reasonable chance of ever waking up (such as after brain damage caused by loss of blood or oxygen to the brain or head injury).
- **Permanent Confusion:** I am unable to remember, understand or make decisions. I do not recognize my loved ones and/or I am unable to have a clear conversation with them (an example is end stage Alzheimer's dementia).
- **Total Dependence:** I am unable to talk clearly or move by myself. I depend on others for feeding and hygiene and I am unable to communicate. My condition cannot be helped by rehabilitation or any other means (an example is severe stroke with paralysis and loss of speech).

Treatment Choices (which attempt to prolong life):

Choosing "No" means I have chosen to let death take its course naturally without medical interference. Treatment to relieve pain and suffering will continue.

- **CPR (Cardiopulmonary Resuscitation):** To attempt to make my heart beat again after it has stopped and to make me start breathing after breathing has stopped, usually involving electric shock to the chest, repeated chest compression, placement of a breathing tube in the throat, and use of a breathing machine.
- **Life support:** The use of machines to do the job of failed organs, typically in a hospital critical care unit.
- **Surgery, lab studies, blood transfusion, antibiotics, etc.:** These are tests and treatments to diagnose and treat specific conditions. When I have no reasonable chance of recovery, such tests and treatments offer no benefit and may prolong unnecessary suffering and interfere with dying naturally.
- **Tube feeding:** When I have no reasonable chance of recovery and I cannot swallow, use of tubes to deliver artificial nutrition and hydration to my stomach or into my vein provides no comfort, but may unnecessarily prolong my suffering.

PROJECT GRACE ADVANCE CARE PLAN

I _____ want to choose how I will be treated during the last days of my life. I request to be given medical treatment fully sufficient to prevent unnecessary suffering, including pain, suffocation, and emotional and psychological stress. When I can no longer make my own health care choices, I direct my physician(s), other health care providers, and my health care surrogate(s) to follow the advance directives of this document. My choices about treatments for four conditions that have little or no chance of recovery are:

I encourage my surrogate and physician to involve Hospice at the earliest opportunity.

_____
(initials)

TREATMENT CHOICES FOR CONDITIONS THAT HAVE LITTLE OR NO CHANCE OF RECOVERY:

(Checking *"YES"* means I *WANT* the treatment for the condition listed. Checking *"NO"* means I *DO NOT WANT* the treatment for the condition listed.)

Illness/Conditions	CPR (Heart/Lung Resuscitation)		Life Support (by Machines)		Surgery, Blood, Antibiotics, Lab Studies, etc.		Tube Feeding by Vein or Stomach Tube	
End Stage Disease:	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No
Permanent Unconscious State:	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No
Permanent Confusion:	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No
Total Dependence:	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No	❑ Yes	❑ No

Other Instructions: _____

_____

_____

Should I meet medical criteria, I do _____ I do not _____ wish to donate my organs and/or tissues for the benefit of others.

Choice of Surrogate for Health Care Affairs

When I am unable to express my own choices or provide consent to withhold or discontinue life-prolonging medical treatment, I appoint the following person(s) to make treatment choices for me consistent with the spirit of this document and my previous expressed choices:

Designate:	**Alternate(if Designate unavailable):**
Tel. No. ( )	Tel. No. ( )
Address	Address

I hereby hold harmless my physicians and any other health care providers who render care or withhold treatment from me in good faith, if they reasonably believe such action(s) is/are consistent with my expressed wishes. I further request that my family and anyone acting on my behalf follow my wishes and directives and take whatever steps are necessary, including legal action, to ensure that my wishes and directives are carried out. I direct my Power of Attorney or Trustee holding funds on my behalf to make such funds available to my healthcare surrogate or anyone acting on my behalf to ensure that my wishes, as expressed herein, are carried out.

Print Your Name:	**Signature:**
Address	Tel. No. ( )
City, State	Dated
Witness – Print Name:	**Signature:**
Address	
Witness – Print Name:	**Signature:**
Address	

(Health care surrogates may NOT serve as a witness to this document. One witness must NOT be your spouse or blood relative.)

WHAT TO DO WITH THIS ADVANCE CARE PLAN DOCUMENT

- Always keep your original document. Put it with your personal files where it is accessible to others.
- Give a copy to your physician(s).
- Take a copy to the hospital each and every time you are admitted.
- Give a copy to your designated Health Care Surrogate, explain the meaning and purpose of your Advance Care Plan to your surrogate, and have an in-depth discussion about your goals of care and wishes at end-of-life.
- Tell your closest relatives what is in your Advance Care Plan document.
- Give a copy to your spiritual leader.
- If you have a pre-existing Living Will or Advance Care Plan, destroy the old document and any existing copies and give copies of your new document to the above listed individuals.
- Some states require an additional state form to be completed if you do not want cardiopulmonary resuscitation (CPR) attempted. You should check with your health care provider or state health officials to find out if your State requires an additional form to prevent CPR (Do Not Attempt Resuscitation Form or "DNR" form).
- If you feel this document is useful to you, share the idea with friends and relatives and refer them to Project GRACE for further information and their own Advance Care Plan.

For inquiries:

Project GRACE • 5771 Roosevelt Blvd. • Clearwater, FL 33760
Phone (727) 536-7364 • **Toll Free 1-877-99-GRACE** • Fax (727) 536-7365
www.projectgrace.org