BAPTIST HEALTH®
ADVANCE CARE PLANNING

Hospital Staff:
Insert Patient MRN Sticker Here

Living Will Directive

Name: ______________________________ Date of Birth: ______________

If I am no longer able to make my own healthcare decisions, this document names the person I choose to make these choices for me as my healthcare surrogate. This person will make my healthcare decisions when I am determined to be incapable of making healthcare decisions as provided under Kentucky law. I understand that it is important for my healthcare surrogate and me to have ongoing discussions about my health and healthcare choices. If I do not designate a surrogate, this document contains my wishes regarding life-prolonging treatment and artificially provided nutrition should I no longer be able to make my own healthcare decisions.

My Wishes Regarding Healthcare Surrogate

When selecting someone to be your healthcare surrogate, choose someone who knows you well, whom you trust, and who is willing to respect your views and values. Choose someone who will closely follow your wishes and will be a good advocate for you. Take time to discuss this document and your wishes with your healthcare surrogate and your healthcare providers.

By checking and initialing the appropriate lines, I, specifically:

☐ ________ Designate ______________________ as my healthcare surrogate(s) to make health care decisions for me in accordance with this directive when I no longer have decisional capacity.

If the above designated surrogate(s) refuses or is not able to act for me, I designate ______________________ as my healthcare surrogate(s).
Any prior designation is revoked.

Contact Information for Healthcare Surrogate *(if known)*:

Name ______________________ Relationship ______________________

Telephone (Home) ______________ (Work) ______________ (Cell) ______________

Address ____

City ______________________________ State ________ ZIP ________

Contact Information for Alternate Healthcare Surrogate *(if known)*:

Name ______________________ Relationship ______________________

Telephone (Home) ______________ (Work) ______________ (Cell) ______________

Address ____

City ______________________________ State ________ ZIP ________

My Wishes Regarding Life-Prolonging Treatments

My healthcare surrogate shall make decisions consistent with my stated desires and values. He or she is subject to any special instructions or limitations that I may list here. The following are some specific instructions for my healthcare surrogate and/or physician providing my medical care if I no longer have decisional capacity, have a terminal condition, or become permanently unconscious.

If I reach a point where there is reasonable medical certainty that I will not recover my ability to know who I am, who my family and friends are, or where I am, I want to be kept comfortable and clean, and I specifically:

Initial and check the box beside the statement or statements you agree with.

Life-Prolonging Treatment *(check and initial only one)*

☐ ________ Direct that treatment be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical treatment deemed necessary to alleviate pain.

☐ ________ DO NOT authorize that life-prolonging treatment be withheld or withdrawn.

Nourishment and/or Fluids *(check and initial only one)*

☐ ___________ Authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

☐ ___________ DO NOT authorize the withholding or withdrawal of artificially provided food, water, or other artificially provided nourishment or fluids.

Healthcare Surrogate Determination of Best Interest
(only check and initial this statement if no prior statements have been selected)

☐ ___________ Authorize my surrogate, designated above, to withhold or withdraw artificially provided nourishment or fluids, or other treatment if the surrogate determines that withholding or withdrawing is in my best interest; but I do not mandate that withholding or withdrawing.

Organ, Tissue, or Eye Donation

☐ ___________ Authorize the giving of all or any needed organs, tissues, and eyes/corneas upon death for any purpose specified in KRS 311.1929.

☐ ___________ DO NOT authorize the giving of all or any part of my body upon death.

☐ ___________ Authorize the giving of only the following organs/tissues as listed if possible:

____

____

Wishes Regarding Cardiopulmonary Resuscitation (CPR)

This document is ***not*** a Do Not Resuscitate Order. In the event of a medical emergency, CPR may be administered by emergency or hospital personnel. If you do not want CPR attempted, your physician should be made aware of this choice. Please talk to your healthcare provider about creating an Emergency Medical Services Do Not Resuscitate order (EMS DNR) or Medical Orders for Scope of Treatment (MOST) Form indicating your CPR wishes in the event that you do not want CPR attempted by emergency personnel.

Other instructions or limitations I want my healthcare surrogate and/or doctor to follow:

____

____

____

In the absence of my ability to give directions regarding the use of life-prolonging treatment and artificially provided nutrition and hydration, it is my intention that this directive shall be honored by my attending physician, my family, and any surrogate designated pursuant to this directive as the final expression of my legal right to refuse medical or surgical treatment and I accept the consequences of the refusal.

If I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this directive shall have no force or effect during the course of my pregnancy.

I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed this ____________ day of _________________, 20____________

____

Grantor Signature *(Document must be signed by the grantor or at the grantor's direction)*

____

Address of Grantor

In our joint presence, the grantor, who is of sound mind and eighteen (18) years of age, or older, voluntarily dated and signed this writing or directed it to be dated and signed for the grantor. *(Document must be witnessed by two or more adults in the presence of the grantor OR acknowledged before a notary public)*

____

Signature and address of witness.

____

Signature and address of witness.

OR

STATE OF KENTUCKY (________________________________ County)
Before me, the undersigned authority, came the grantor who is of sound mind and eighteen (18) years of age, or older, and acknowledged that he voluntarily dated and signed this writing or directed it to be signed and dated as above.

Done this ______________ day of _________________, 20____________

____

Signature of Notary Public or other officer

Notary ID Number: ____ Date commission expires: ________________________

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