Baptist Health

2130

My Name: _____

My Date of Birth: _____

Advance Healthcare Directive

If I, _____, become unable to make my own medical decisions, this Advance Healthcare Directive tells my doctors and nurses what I want**. As long as I am able to make my own decisions, this form will not be necessary.**

QUALITY OF LIFE

A quality of life that is unacceptable to me means I have either of the following conditions (you may check one box, both boxes, or neither).

☐	***Permanent Unconscious Condition*:** I have an incurable and irreversible condition in which there is no reasonable probability of recovery from an irreversible coma or a permanent vegetative state.
☐	***End Stage Illness*:** I have an illness that has reached its final stages in spite of full treatment, such as widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

TREATMENT

Which of the following treatments do you want IF the quality of your life becomes irreversible and unacceptable to you? By checking **"yes,"** you are saying that **I want** the treatment. By checking **"no,"** you are saying **I do not want** the treatment.

☐ **Yes**	☐ **No**	**CPR (Cardiopulmonary Resuscitation)**: To make the heart beat again and restore breathing after it has stopped. This usually involves electric shock, chest compressions, and breathing assistance.
☐ **Yes**	☐ **No**	**Life Support** / **Other Artificial Support**: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ **Yes**	☐ **No**	**Treatment of New Conditions**: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ **Yes**	☐ **No**	**Tube Feeding** / **IV Fluids**: Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

If there is anything else you would like to share with your doctors, caregivers, or family, please write it on these blank lines: _____

_____

Signatures required on next page ➡

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2130

Sign this Document

I want my doctors, my healthcare agent (the person I appoint to make medical decisions on my behalf should I become unable), and any other caregiver to follow my healthcare wishes as indicated in this document. I intend for this document to serve as my advance care plan under the Arkansas Healthcare Decisions Act. I understand that I can change my mind at any time by creating a new Advance Healthcare Directive or by verbally telling my doctors, my healthcare agent, or my caregivers that my wishes have changed.

_____

My Signature **Date** **Time**

To complete this Advance Healthcare Directive, please have *either* **Option 1** witnessed and signed *or* **Option 2** notarized.

Option 1: Two Witnesses

Witness #1: I am a competent adult who is not named as the patient's healthcare agent. I witnessed the patient sign this form.

_____

Signature of Witness #1 **Date** **Time**

Witness #2: I am a competent adult who is not named as the patient's healthcare agent. I am not related to the patient by blood, marriage, or adoption. I am not entitled to anything from the patient's estate. I witnessed the patient sign this form.

_____

Signature of Witness #2 **Date** **Time**

Option 2: Notary

State of Arkansas, County of _____

I am a Notary Public in and for the State and County named above. The person who signed this form is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is signed above. This person personally appeared before me and signed the above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

_____

Date Commission Expires **Signature of Notary Public** **Date** **Time**