ADVANCE DIRECTIVE

Children's National

Words You Need To Know

Advance Directive
A written document that tells what a person wants or does not want if, in the future, he/she can't make his/her wishes known about medical treatment.

Artificial Nutrition and Hydration
When food and water are given to a person through a tube.

Autopsy
An examination done on a dead body to find the cause of death.

Comfort Care
Care that helps to keep a person comfortable but does not intend to cure. Bathing, turning, keeping a person's lips moist are types of comfort care.

CPR (Cardiopulmonary Resuscitation)
Treating to try and restart a person's breathing or heartbeat. CPR may be done by pushing on the chest, by putting a tube down the throat, or by other treatments.

Durable Power of Attorney for Health Care
An advance directive appoints someone to make medical decisions for a person if in the future he/she cannot make his/her own medical decisions.

Life-Sustaining Treatment
Any medical treatment that is used to keep a person from dying. A breathing machine, CPR, and artificial nutrition and hydration are examples of life-sustaining treatments.

Living Will
An advance directive that tells what medical treatment a person does or does not want if he/she is not able to make his/her wishes known.

Organ and Tissue Donation
When a person permits his/her organs (such as eyes or kidneys) and other parts of the body (such as skin) to be removed after death to be transplanted for use by another person or to be used for experimental purposes.

Persistent Vegetative State
When a person is unconscious with no reasonable expectation of regaining consciousness even with medical treatment. The body may move and eyes may be open but as far as anyone can tell, the person cannot think or respond.

Terminal Condition
An on-going condition caused by injury or illness that has no cure and from which doctors expect the person to die even with medical treatment.

Your Durable Power of Attorney For Health Care, Living Will & Other Wishes

This document has been prepared and distributed as an information service of the District of Columbia Hospital Association.

INSTRUCTIONS AND DEFINITIONS

Introduction

This form is a combined Durable power of Attorney for Health Care and Living Will for use in the District of Columbia, Maryland and Virginia.

With this form, you can:

- Appoint someone to make medical decisions for you if you in the future are unable to make those decisions for yourself;
- And/or
- Indicate what medical treatment you do or do not want if in the future you are unable to make your wishes known.

Directions

- Read each section carefully.
- Talk to the person you plan to appoint to make sue that he/she understands your wishes, and is willing to take the responsibility.
- Place the initials of your name in the blank before those choices you want to make.
- Fill in only those choices that you want under Parts 1, 2 and 3. Your advance directive should be valid for whatever parts you fill in, as long as it is properly signed.
- Add any special instructions in the blank spaces provided. You can write additional comments on a separate sheet of paper, but should indicate on the form that there are additional pages to your advance directive.
- Sign the form and have it witnessed.
- Give your doctor, nurse, the person you appoint to make your medical decisions for you, your family and anyone else who might be involved in your care, a copy of your advance directive and discuss it with them.
- Understand that you may change or cancel this document at any time.

For more information call:

Social Work Services, Department of Family Services
(202)476-3070

ADVANCE DIRECTIVE INTERIM FORM

This form is to be completed by a patient ***who has*** an Advance Directive, but ***does not have an available*** copy upon admittance to Children's National Medical Center. This form will serve as a substitute verification of the patient's wishes until the original Advance Directive is presented.

☐ I have an ADVANCE DIRECTIVE that has **NOT BEEN** provided to the Children's National Medical Center. I understand that to protect the right I have already demonstrated through an advance directive, I need to communicate my wishes in regards to my future medical care to my healthcare providers. As such, the intent of my advance directive is as follows:

	YES	NO
If I am in a terminal condition I want medically appropriate methods used to keep me alive.	☐	☐
IF YOU ANSWERED **NO**, COMPLETE THE FOLLOWING SIX QUESTIONS		
1. **To be kept on a ventilator** (a mechanical device to assist with breathing)?	☐	☐
2. **CPR** (Cardiopulmonary Resuscitation . . . Emergency medical procedures to stimulate heart and /or provide air into the lungs)?	☐	☐
3. **Antibiotics** (medication to fight infection)?	☐	☐
4. **Pain medication** (providing pain medication to relieve pain even if it may lead to reduced consciousness and/or shorten life)?	☐	☐
5. **To be fed by a tube to your stomach if you cannot eat?**	☐	☐
6. **To be medically fed and hydrated?**	☐	☐

☐ **I cannot remember any of the content of my advance directive and wish to fill out another one.**

I have appointed a Durable Power of Attorney or Healthcare Surrogate: ☐ Yes ☐ No

If you have not appointed a Durable Power of Attorney or healthcare surrogate, is there anyone you want to make decisions for you if you are not able to speak for yourself?

Name:	Phone:

At any time, you may change your mind about any of the answers given to any of these questions by informing your nurse attending physician,

Comments you would like to make:

I understand and agree that this document will serve as a recording of the substance of my existing Advance Directive until I provide a copy to the Children's National Medical Center. **CNMC staff cannot witness the signature.**

Signature of Patient	**Date:**
Witness:	**Date:**

-ADC-

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My Durable Power of Attorney for Health Care, Living Will and Other Wishes

I, _____, write this document as a directive regarding my future medical care.

Put the initials of your name by the choices you want.

PART 1. MY DURABLE POWER OF ATTORNEY FOR HEALTH CARE

	I appoint this person to make decisions about my medical care if there ever comes a time I cannot make those decisions myself.		If the person I appointed first cannot or will not make decisions for me, I appoint this person:
Name		Name	
Home Phone		Home Phone	
Work Phone		Work Phone	
Address		Address	

	I have not appointed anyone to make health care decisions for me in any other document.

I want the person I have appointed, my doctors, my family, and others to be guided by the decisions I have made below.

PART 2. MY LIVING WILL

These are my wishes for my future medical care if there ever comes a time when I can't make these decisions for myself.

A. These are my wishes if I have a **terminal condition**:		**B.** These are my wishes if I am ever in a **persistent vegetative state**:	
Life-Sustaining Treatments		**Life-Sustaining Treatments**	
	I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.		I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.
	I want life-sustaining treatments that my doctors think are best for me.		I want life-sustaining treatments that my doctors think are best for me.
	Other wishes:		Other wishes:
Artificial Nutrition and Hydration		**Artificial Nutrition and Hydration**	
	I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.		I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.
	I want artificial nutrition and hydration even if it is the main treatment keeping me alive.		I want artificial nutrition and hydration even if it is the main treatment keeping me alive.
	Other wishes:		Other wishes:
Comfort Care		**Comfort Care**	
	I want to be kept as comfortable and free of pain as possible even if such care speeds up my dying or shortens my life.		
	Other wishes:		Other wishes:

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Other Directions
You have the right to be involved in all decisions about your medical care, even those not dealing with terminal conditions or persistent vegetative states. If you have wishes not covered in other parts of this document, please indicate them here.

PART 3. OTHER WISHES

Organ Donation		Autopsy	
☐	I want to donate all of my organs and tissues.	☐	I agree to an autopsy if my doctor wishes it.
☐	I only want to donate these organs and tissues:	☐	I do not want an autopsy.
☐	I do not wish to donate any of my organs and tissues.		
☐	Other wishes:		
			If you wish to say more about any of the above choices, or if you have any other statements to make about your medical care, you may do so on a separate sheet of paper. If you do so, put the number of pages you are adding here: ☐

PART 4. SIGNATURES

You and two witnesses must sign this document in order for it to be legal.

Your Signature	
By my signature below I show that I understand the purpose and the effect of this document.	Date
Print Name	Signature
Address	

Your Witnesses' Signature **(CNMC staff cannot witness the signature.)**

I believe the person who has signed this advance directive to be of sound mind, that he/she signed or acknowledged this advance directive in my presence, and that he/she appears not to be acting under pressure, duress, fraud, or undue influence. I am not related to the person making this advance directive by blood, marriage or adoption, nor, to the best of my knowledge, am I named in his/her will. I am not the person appointed in this advance directive. I am not a health care provider or an employee of a health care provide who is now, or has been in the past, responsible for the care of the person making this advance directive.

Witness #1		Witness #2	
Print Name		Print Name	
Signature	Date	Signature	Date
Address		Address	