Sentara®

ADVD

My Advance Care Plan—North Carolina

Communicating my healthcare wishes

Name _____ Social security number XXX - XX - _____

Address _____ City _____ State _____ Zip _____

Phone: (_____)_____ Date of birth _____ - _____ - _____

(Cross out any section(s) you do not wish to include in your document.)

Section 1: Healthcare agent

If I am unable to make decisions for myself, or unable to communicate my healthcare wishes about treatment, I appoint the person(s) listed below to be my designated healthcare agent(s), who will make my wishes known to my healthcare providers. I direct my healthcare providers and family to respect and honor my wishes.

Primary healthcare agent

Name _____ Phone: (_____)_____

Address _____ City _____ State _____ Zip _____

Secondary healthcare agent

Name _____ Phone: (_____)_____

Address _____ City _____ State _____ Zip _____

_____ If I initial this line, my agent **WILL** have the authority to restrict visitors in a healthcare facility.
(Initials)

Section 2: Advance directive for a natural death

The below information will guide the decisions of your healthcare agent and providers if you can no longer make decisions for yourself. **Initial** beside any below instructions you wish to include.

If I lack sufficient understanding or capacity to make or communicate decisions relating to my healthcare, and:

_____ I have an incurable or irreversible condition that will result in my death within a relatively short period of time.
(Initials)

_____ I become unconscious, and my healthcare providers determine, to a high degree of medical certainty, I will never regain consciousness.
(Initials)

_____ I suffer from advanced dementia or any other condition which results in the substantial loss of my cognitive ability and my healthcare providers determine, to a high degree of medical certainty, this loss is not reversable.
(Initials)

Then:

_____ I do not want any treatments to prolong my life. This includes tube feeding, IV fluids, cardiopulmonary resuscitation (CPR), ventilator/respirator (breathing machine), kidney dialysis or antibiotics. I am aware that this declaration authorizes a physician to withhold or discontinue these life prolonging measures. I will still receive treatment to relieve pain and make me comfortable. **OR**
(Initials)

_____ I want all treatments to prolong my life as long as possible within the limits of generally accepted healthcare standards.
(Initials)

_____ If medically appropriate, I wish to include the following treatment instructions: _____
(Initials)

_____

_____

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Section 3: Anatomical gift (whole body) or organ donation

_____ I wish to be an organ donor (Initials) **OR** _____ I wish to be an anatomical gift (whole body) donor (Initials)

For more information and to complete the registration to be an organ donor or anatomical gift (whole body) donor, please visit your local/state organ and/or anatomical donation programs.

Section 4: If I have an available healthcare agent

If I have appointed a healthcare agent in Section 1 of this advance care plan or other similar document, and a healthcare agent gives instructions about prolonging life that ***differ from*** my wishes expressed in those documents, then:

_____ **Follow this advance care plan.** My healthcare agent ***does not*** have the authority to override my expressed wishes.
(Initials)

_____ **Follow the healthcare agent.** My healthcare agent ***has*** the authority to override my expressed wishes.
(Initials)

NOTE: Do not initial both lines. If you **DO NOT** initial either line, your healthcare providers will disregard any instructions from your healthcare agent(s) about prolonging life that differ from the wishes contained in this advance care plan or other similar documents.

Section 5: Signatures (required)

By signing below, I indicate that I understand this document and I am willingly and voluntarily executing it. I also understand that I may revoke all or any part of it at any time as provided by law.

My signature _____ **Date** _____

Two witness signatures and notarization (required)

I hereby state that the declarant/principal being of sound mind, signed this document in my presence. I am not related to the declarant/principal by blood or marriage, and I would not be entitled to any portion of the estate of the declarant/principal under any existing will or codicil, or as an heir under the Intestate Succession Act if the principal died on this date without a will. I also state that I am not the declarant/principal's attending physician, nor a licensed healthcare provider who is an employee of the attending physician, an employee of the healthcare facility in which the declarant/principal is a patient, or an employee of a nursing home or adult care home where the declarant/principal resides. I further state that I do not have any claim against the declarant/principal or the estate of the declarant/principal.

Witness signature #1 _____ **Date** _____

Witness signature #2 _____ **Date** _____

_____ County, _____ State

Sworn to (or affirmed) and subscribed to me this day by: _____ **(Print declarant name)**

_____ **(Print witness #1 name)**

_____ **(Print witness #2 name)**

Date _____

(Official seal)

Notary signature _____

Notary name _____, Notary Public

My commission expires _____

Patient label