HCHC
HOMESTEAD COMMUNITY HEALTH CENTER

Advance Directives

The Patient Self-Determination Act requires that we ask you whether or not you have an advance directive or would like to execute an advance directive when you are admitted to the clinic.

Advance directives is a general term for written or oral statements that allow you to express your wishes about life-prolonging procedures at the end of life, as well as the person you may choose to appoint to make healthcare decisions for you if you become unable to make these decisions for yourself or if you would like someone else involved in making these decisions on your behalf.

Our intent in providing this information to you is for you to think ahead about these important decisions. Our desire is to provide you with the best healthcare in accordance with your wishes. Please execute the advance directive if you choose, though you are not required to do so. If you would like assistance or if you have questions, please contact:

Vilma LaPorte
Social Worker/ Case Manager
786-904-4242

ADVANCE DIRECTIVES

You may fill out any, all or none of the two sections below.

Designation of Healthcare Surrogate

Fill this out if you wish to choose someone to make all your healthcare decisions and/or receive your health information. This person is called a healthcare surrogate.

I, _____, born ____/____/____, wish to designate as my SURROGATE to carry out the provisions of this declaration:

Name:_____ Relationship: _____

Phone:_____ Address: _____

If my surrogate is not willing, able, or reasonably available to perform his/her duties, I designate as my ALTERNATE SURROGATE:

Name:_____ Relationship: _____

Phone:_____ Address: _____

❑ I have ❑ I have not formulated a Living Will before this admission.

INSTRUCTIONS FOR HEALTHCARE

I authorize my healthcare surrogate to:

❑ _____ ***(Initial here)*** Receive any of my health information, whether oral or recorded in any form or medium, that:

1. Is created or received by a healthcare provider, healthcare facility, health plan, public health authority, employer, life insurer, school or university, or healthcare clearinghouse; and
2. Relates to my past, present or future physical or mental health or condition; the provision of healthcare to me; or the past, present or future payment for the provision of healthcare to me.

I further authorize my healthcare surrogate to:

❑ _____ ***(Initial here)*** Make all healthcare decisions for me, which means he or she has the authority to:

1. Provide informed consent, refusal of consent or withdrawal of consent to any and all of my healthcare, including life-prolonging procedures.
2. Apply on my behalf for private, public, government or veterans' benefits to defray the cost of healthcare.
3. Access my health information reasonably necessary for the healthcare surrogate to make decisions involving my healthcare and to apply for benefits for me.
4. Decide to make an anatomical gift pursuant to part V of chapter 765, Florida Statutes.

❑ _____***(Initial here)*** Additional instructions (optional): _____

My healthcare surrogate's authority becomes effective when my primary physician determines that I am unable to make my own healthcare decisions unless I check and initial either or both of the following boxes:

❑ _____ If I check and initial this box, my healthcare surrogate's authority to receive my health information takes effect immediately.

❑ _____ If I check and initial this box, my healthcare surrogate's authority to make healthcare decisions for me takes effect immediately. However, any instructions or healthcare decisions I make, either verbally or in writing, while I possess capacity shall supersede any instructions or healthcare decisions made by my surrogate that are in material conflict with those made by me.

While I have decision-making capacity, my wishes are controlling and my physicians and healthcare providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation. To the extent I am capable of understanding, my healthcare surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

THIS HEALTHCARE SURROGATE DESIGNATION IS NOT AFFECTED BY MY SUBSEQUENT INCAPACITY EXCEPT AS PROVIDED IN CHAPTER 765, FLORIDA STATUTES.

I understand that I may, at any time while I retain my capacity, revoke or amend this designation by: (1) providing a signed, written and dated document expressing my intent to amend or revoke it; (2) destroying it either by my action or by that of another person in my presence and at my request; (3) verbally expressing my intent to amend or revoke this designation; or (4) signing a new designation that is materially different from this designation.

Signature: *Sign the form.* ***Have two witnesses sign the form.*** *Tell others about your decision and give copies to your doctor and family. Bring the form to the hospital at the time of admission.*

I understand the importance of this declaration, and I am emotionally and mentally competent to make this declaration. These directives express my legal right to preserve my right to privacy and self-determination. Therefore, I expect my family, physician and all those concerned with my care to regard themselves as legally and morally bound to act according to my wishes.

Patient's Signature	Date	Witness to Signature	Witness to Signature
ONLY ONE OF THE WITNESSES MAY BE A SPOUSE OR BLOOD RELATIVE. A SURROGATE CANNOT BE A WITNESS.		Print Name/Relationship	Print Name/Relationship

Living Will

Fill this out if you choose, or you may provide a document of your own.

Patient Name: _____

Last name First name Middle initial

Declaration made this_____ day of _____ in the year of_____ I, _____, born ____/____/____, willfully and voluntarily make known my desire that my dying shall not be prolonged under the circumstances set forth below:

It is my wish that my life not be artificially prolonged if I am unable to communicate healthcare decisions and: I have a terminal condition; or I have an end-stage condition; or I am in a persistent vegetative state. If my doctor determines that there is no reasonable probability of my recovery, and another consulting physician confirms this, then I request that life-prolonging procedures be withheld or withdrawn. Medications and medical procedures should be provided only if they give me comfort or ease my pain.

Other personal instructions: _____

_____

My family and physicians should honor this declaration as the final expression of my right to refuse medical or surgical treatment, even if the consequence is my death.

❑ I have ❑ I have not designated a healthcare surrogate before this admission.

Signature: *Sign the form.* ***Have two witnesses sign the form.*** *Tell others about your decision and give copies to your doctor and family. Bring the form to the hospital at the time of admission.*

I understand the importance of this declaration, and I am emotionally and mentally competent to make this declaration. These directives express my legal right to preserve my right to privacy and self-determination. Therefore, I expect my family, physician and all those concerned with my care to regard themselves as legally and morally bound to act according to my wishes.

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