



Dying With Dignity Canada
It's your life. It's your choice.

BRITISH COLUMBIA

Advance Directive: Instructions

Read the Advance Directive Form all the way through, but do not start to fill in the form until you have read the directions on how to do so. The Advance Directive Form is first, followed by the form to appoint your Substitute Decision-Maker for Health (called a Representative in British Columbia). Make sure you understand all the information and are satisfied that your Representative understands that these are your wishes and is willing to act on your behalf. If English is not your first language, or you need general assistance, seek help from a trusted friend or family member when completing these forms.

- 1.** Read each line carefully and strike out any that do not apply to you or that you do not agree with. There are extra spaces for you to fill in any circumstances not covered – e.g. you may have a hereditary condition you want to address.
- 2.** Please pay special attention to Section 4 in the Advance Directive Form. If you **DO NOT WISH** to have your life prolonged under the conditions you have set out in Sections 1, 2 and 3 then you must strike out Section 4 completely. If you **DO WISH** to have your life prolonged under any circumstances, and are requesting all treatment applicable to your medical condition, then you must strike out Sections 1, 2 and 3 completely and leave only the directions you are giving under Section 4.
- 3.** Please note that your signature needs to be **witnessed by two people**. Your Representative **CANNOT** also act as witness.
- 4.** Make copies of the Advance Directive Form before you sign and date, so that each copy has the original signatures.

5. Talk to your physician and ask that a copy of the directive be entered in your medical records. Give a copy to whoever will be making decisions on your behalf if you cannot do so for yourself. Keep a copy where it can be easily found in an emergency situation. Leave a note in a prominent place – perhaps with a fridge magnet – saying where to find your Advance Directive and who to call in an emergency. Do not store your Advance Directive in a safety deposit box.

6. Get into the habit of reviewing your Advance Directive, Representation Agreement, Will and Enduring Power of Attorney every year when you file your tax return.

CHANGING YOUR MIND:

You can always change your mind. There is no requirement under British Columbia law that you update your signature. However, your Advance Directive may not come into effect for a long time. Therefore, we advise that you review your Advance Directive at least every three years. If there are no changes to be made, sign it again with the new date. There is space at the bottom of the form for you to do this. Keeping your Advance Directive up-to-date helps ensure that your most current wishes will be reflected if you lose capacity to make health decisions.

If your medical condition has changed, or if you have reconsidered some of the answers you wrote down, ask us to send you a new form, and start over. Begin by revoking your previous Advance Directive and continue on as before. Be sure to tell everyone involved in your care that you have revised your directive.

Advance Directive: Form

Made under the *Health Care (Consent) and Care Facility (Admission) Act*

The use of this form is voluntary. Before completing this Advance Directive, it is advisable to obtain legal advice and the advice of a health care provider about the possible implications of this Advance Directive, and your choices about the types of health care for which you might give or refuse consent under this Advance Directive.

The notes referenced in this Advance Directive are found at the end of this document and are provided for informational purposes only. (See Note 1 – limitations on the effect of this Advance Directive).

1. THIS IS THE ADVANCE DIRECTIVE OF THE “ADULT:”

Full Legal Name of the Adult: _____

Date of Birth (YYYY / MM / DD): _____

Full Address of the Adult: _____

(OPTIONAL) Personal Health (CareCard) Number: _____

2. REVOCATION OF PREVIOUS ADVANCE DIRECTIVES:

I revoke all previous Advance Directives made by me.

3. CONSENT TO HEALTH CARE AND REFUSAL OF CONSENT TO HEALTH CARE:

If I need health care and I am not capable of giving or refusing consent to the health care at the time the health care is required, I give the following instructions:

[Note: If a health care decision is required while you are incapable but the type of health care is not addressed in this Advance Directive, the decision will be made by a Substitute Decision-Maker.]

If I am sedated and unable to communicate, I would like the sedation lifted so that I can rationally consider my situation and decide for myself to accept or refuse a particular therapy.

Yes No

1. In any of the following circumstances, I direct that I receive only such care as will keep me comfortable and pain free, and that my dying not be prolonged:

- a) An acute life-threatening illness of an irreversible nature
- b) Chronic debilitating suffering of a permanent nature
- c) Advanced dementia
- d) _____
- e) _____

2. In the circumstances set out in Section 1 above, I specifically refuse the following:

- a) Electrical, mechanical or other artificial stimulation of my heart
- b) Respirator or ventilator
- c) Artificial feeding e.g. G tube, NG tube, or central intravenous line
- d) Being fed should I no longer be able to feed myself
- e) Artificial hydration by intravenous line
- f) Antibiotics
- g) Transfer to an intensive care unit or similar facility
- h) _____
- i) _____

3. I specifically direct the following:

- a) Provide necessary medication to control my pain and control my symptoms even if such medication might shorten my remaining life
- b) Provide me with palliative care
- c) I would prefer to be cared for and to die at home **OR**
I would prefer to be cared for and to die in hospice

(You must choose only one option under 3c and strike out what does not apply)

- d) _____
- e) _____

Section 4 note: If you **DO NOT WISH** to have your life prolonged under the conditions you have set down in Sections 1, 2 and 3, you must strike out Section 4 completely. If you **DO WISH** to have your life prolonged under any circumstances, and are requesting all treatment applicable to your medical condition, you must strike out Sections 1, 2 and 3 completely and leave only the directions you are giving under Section 4.

4. I specifically direct the following: I desire that my life be prolonged, and that I be provided all life-sustaining treatments applicable to my medical condition.

5. If my health care provider will not follow this Advance Health Care Directive, I ask that my care be transferred to another health care provider who will respect my legal rights.

6. If I should be a patient in a hospital, or resident in a health care or long-term care facility which will not follow this Advance Health Care Directive, I ask that I be transferred to another hospital or care facility.

Section 7 note: If you **DO NOT WISH** to provide directions regarding MAID, strike out this section. If you **DO WISH** to provide directions regarding MAID, write them below.

7. I understand that the current laws of Canada do not allow me to request medical assistance in dying (“MAID”) in advance, or for my SDM to consent to MAID on my behalf. However, if the law changes to allow my SDM and health care providers to act on my directions below, I wish for them to do so. Here are my directions regarding MAID: _____

I consent to the following health care:

I refuse to consent to the following health care:

4. ACKNOWLEDGEMENTS:

I know that as a result of making this Advance Directive:

- a) I will not be provided with any health care for which I refuse consent in this Advance Directive, and
- b) No one will be chosen to make decisions on my behalf in respect of any health care matters for which I give or refuse consent in this Advance Directive. (See Note 1 – limitations on the effect of this Advance Directive)

5. SIGNATURES:

Adult’s Signature

The Adult must sign and date in the presence of both witnesses.

Adult Signature: _____

Date Signed (YYYY / MM / DD): _____

Print Name: _____

Address: _____

Signature of Witness No. 1: _____

Date Signed (YYYY / MM / DD): _____

Print Name: _____

Address: _____

Signature of Witness No. 2: _____

Date Signed (YYYY / MM / DD): _____

Print Name: _____

Address: _____

NOTES RESPECTING ADVANCE DIRECTIVES

The notes provided below are for informational purposes only.

These notes should NOT be considered complete: a person making an Advance Directive should consult the Health Care (Consent) and Care Facility (Admission) Act to ensure that they understand their rights and duties.

NOTE 1: LIMITATIONS ON THE EFFECT OF THIS ADVANCE DIRECTIVE

Note that the effect of this Advance Directive and the giving and refusing of consent under it is subject to the limitations set out in Sections 19.2 (2), 19.3 (1) and 19.8 of the Health Care (Consent) and Care Facility (Admission) Act.

NOTE 2: INFORMATION FOR WITNESSES

a) The following persons may not be a witness:

- i. A person who provides personal care, health care or financial services to the Adult for compensation, other than a lawyer or notary public
- ii. A spouse, child, parent, employee or Agent of a person described in paragraph (a)

- iii. A person who is under 19 years of age
 - iv. A person who does not understand the type of communication used by the Adult, unless the person receives interpretive assistance to understand that type of communication
- b) Only one witness is required if the witness is a lawyer or notary public.
- c) You should not witness the Advance Directive if you have reason to believe that:
- i. The Adult is incapable of making, changing or revoking an Advance Directive, or
 - ii. Fraud, undue pressure or some other form of abuse or neglect was used to induce the Adult to make the Advance Directive, or to change or revoke a previous Advance Directive

Representative Agreement Section 9 (RA9): Instructions

The form for appointing your Substitute Decision-Maker for Health (termed a Representative in British Columbia) is below.

- 1.** You will need **two witnesses** to your signature. The witness **CANNOT** be the person you have appointed as your Representative. If the first witness is a lawyer or notary, then you do not need a second witness.
- 2.** In British Columbia, a Representative Agreement is a stand-alone document. Your Representative is only responsible for health care decisions. If you wish to appoint a Substitute Decision-Maker for Finances, you must create an Enduring Power of Attorney. You can appoint the same person for both, or you can appoint one person for your personal and medical care, and a different person for your financial and legal affairs.
- 3.** Please note: You should consult with your lawyer if you:
 - a) Wish to appoint multiple health representatives to act jointly
 - b) Have special circumstances the Dying with Dignity Canada forms do not address

Taking legal advice will ensure that you fully understand all your available options and that your Representation Agreement fulfills the legal requirements of your province. The form provided in this Advance Care Planning Kit is for the stand-alone Representative Agreement 9 (RA9).

- 4.** Keep a copy of your Representative Agreement 9 (RA9) where it can be easily found in an emergency situation and leave a note in a prominent place giving the location of your Representative Agreement 9 (RA9) Form and your Advance Directive Form, and who to call in an emergency. Do not store your copy of these documents in a locked safety deposit box.

CHANGING YOUR MIND:

You can always change your mind. Simply start off by stating that you revoke any previous Representative Agreement and then continue to complete a new form in the same way as before. Make sure to inform your previous Representative and anyone else to whom you gave a copy of the Representative Agreement 9 (RA9) Form that you have made these changes.

Representative Agreement 9 (RA9): Form

I revoke any previous Representation Agreement(s) I have made.

1. This Power of Attorney is given by _____ (Name) of _____ (city) in the Province of British Columbia.

2. I appoint _____ to be my Representative in accordance with section 9 of the Representative Agreement Act.

3. If the above named _____ should be or become at any time unable or unwilling to act in the office of attorney, then I appoint _____ to be my Representative in accordance with section 9 of the Representative Agreement Act.

4. I give my Representative authority to make decisions on my behalf for all personal care and health care matters of a non-financial nature that relate to me.

Signatures:

Maker:

I have signed this Representative Agreement 9 (RA9) in the presence of the witnesses whose names appears below. I have signed this Representative Agreement 9 (RA9) on _____ (date)

Signature: _____

Address: _____

Witness No. 1:

Signature: _____ Date: _____

Print Name: _____

Address: _____

Witness No. 2:

Signature: _____ Date: _____

Print Name: _____

Address: _____

Representative:

Signature: _____ Date: _____

Print Name: _____

Address: _____