Arizona Advance Health Care Directive

Thoughtful Life Conversations
Sponsored by Arizona Hospital and Healthcare Association

This form lets you have a say about how you want to be cared for if you cannot speak for yourself.

This form has 3 parts:

Part 1 Choose a medical decision maker, Page 3

A medical decision maker is a person who can make health care decisions for you if you are not able to make them yourself.

This person will be your advocate.

They are also called a health care agent, proxy, or surrogate.

Part 2 Make your own health care choices, Page 7

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

Part 3 Sign the form, Page 13

The form must be signed before it can be used.

You can fill out Part 1, Part 2, or both. Fill out only the parts you want.

You can also name a mental healthcare decision maker on Page 12a.

Always sign the form in Part 3 on Page 13.

1 witness needs to sign on Page 14, or a notary on Page 15.

You can also attach other forms (POLST or Prehospital Form) at the end of this form.

For more information, call: 602-445-4300 or email: tlc@thoughtfullifeconversations.org

Developed by PREPARE™ for your care
www.prepareforyourcare.org

Your Name

This is a legal form that lets you have a voice in your health care.

It will let your family, friends, and medical providers know how you want to be cared for if you cannot speak for yourself.

What should I do with this form?

- Please share this form with your family, friends, and medical providers.
- Please make sure copies of this form are placed in your medical record at all the places you get care.

What if I have questions about the form?

- It is OK to skip any part of this form if you have questions or do not want to answer.
- Ask your doctors, nurses, social workers, family, or friends to help.
- Lawyers can help too. This form does not give legal advice.

What if I want to make health care choices that are not on this form?

- On Page 12, you can write down anything else that is important to you.

When should I fill out this form again?

- If you change your mind about your health care choices
- If your health changes
- If your medical decision maker changes

Give the new form to your medical decision maker and medical providers.

Destroy old forms.

Share this form and your choices with your family, friends, and medical providers.

Part 1 Choose your medical decision maker

Your medical decision maker can make health care decisions for you if you are not able to make them yourself.

A good medical decision maker is a family member or friend who:

- is 18 years of age or older
- can talk to you about your wishes
- can be there for you when you need them
- you trust to follow your wishes and do what is best for you
- you trust to know your medical information
- is not afraid to ask doctors questions and speak up about your wishes

Legally, your decision maker cannot be someone who has lost their license to manage another person's money and personal affairs, unless they have their license back or they are a family member.

What will happen if I do not choose a medical decision maker?

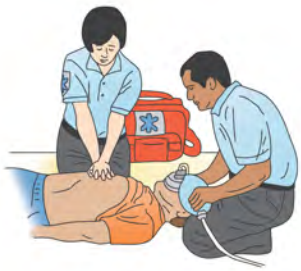
If you are not able to make your own decisions, a person will be chosen for you according to Arizona law. This person may not know what you want.

If you are not able, your medical decision maker can choose these things for you:

- doctors, nurses, social workers, caregivers
- hospitals, clinics, nursing homes
- medications, tests, or treatments
- who can look at your medical information
- what happens to your body and organs after you die

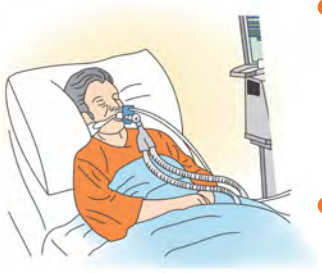
Here are more decisions your medical decision maker can make:

Start or stop life support or medical treatments, such as:



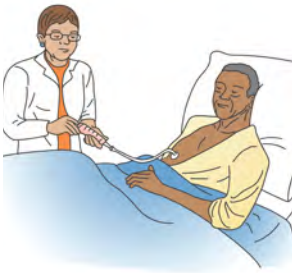
- **CPR or cardiopulmonary resuscitation**
  cardio = heart • pulmonary = lungs • resuscitation = try to bring back

  This may involve:
  - pressing hard on your chest to try to keep your blood pumping
  - electrical shocks to try to jump start your heart
  - medicines in your veins



- **Breathing machine or ventilator**
  The machine pumps air into your lungs and tries to breathe for you. You are not able to talk when you are on the machine.

- **Dialysis**
  A machine that tries to clean your blood if your kidneys stop working.

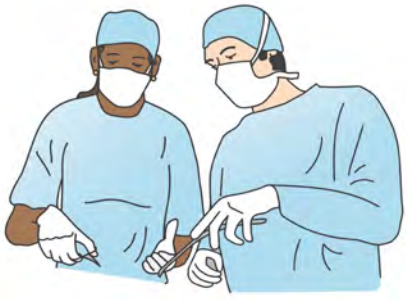


- **Feeding Tube**
  A tube used to try to feed you if you cannot swallow. The tube can be placed through your nose down into your throat and stomach. It can also be placed by surgery into your stomach.

- **Blood and water transfusions (IV)**
  To put blood and water into your body.

- **Surgery**

- **Medicines**



End of life decisions your medical decision maker can make:

- call in a religious or spiritual leader
- decide if you die at home or in the hospital
- decide about autopsy or organ donation
- decide about burial or cremation

Your Name

By signing this form, you allow your medical decision maker to:

- agree to, refuse, or withdraw any life support or medical treatment if you are not able to speak for yourself
- decide what happens to your body after you die, such as funeral plans and organ donation

If there are decisions you do not want them to make, write them here:

Write the name of your medical decision maker.

I want this person to make my medical decisions if I am not able to make my own:

first name | last name

phone #1 | phone #2 | relationship

address | city | state | zip code

If the first person cannot do it, then I want this person to make my medical decisions:

first name | last name

phone #1 | phone #2 | relationship

address | city | state | zip code

Your Name

Why did you choose your medical decision maker?

If you want, you can write why you chose your #1 and #2 decision makers.

Write down anyone you would NOT want to help make medical decisions for you.

How strictly do you want your medical decision maker to follow your wishes if you are not able to speak for yourself?

Flexibility allows your decision maker to change your prior decisions if doctors think something else is better for you at that time.

Prior decisions may be wishes you wrote down or talked about with your medical decision maker. You can write your wishes in Part 2 of this form.

Put an X next to the one sentence you most agree with.

- ☐ **Total Flexibility:** It is OK for my decision maker to change any of my medical decisions if my doctors think it is best for me at that time.
- ☐ **Some Flexibility:** It is OK for my decision maker to change some of my decisions if the doctors think it is best. But, these wishes I NEVER want changed:

- ☐ **No Flexibility:** I want my decision maker to follow my medical wishes exactly. It is NOT OK to change my decisions, even if the doctors recommend it.

If you want, you can write why you feel this way.

To make your own health care choices, go to Part 2 on Page 7.
To name a mental healthcare decision maker, go to Page 12a.
If you are done, you must sign this form on Page 13.
Please share your wishes with your family, friends, and medical providers.

Part 2 Make your own health care choices

Fill out only the questions you want.

How do you prefer to make medical decisions?

Some people prefer to make their own medical decisions. Some people prefer input from others (family, friends, and medical providers) before they make a decision. And, some people prefer other people make decisions for them.

Please note: Medical providers cannot make decisions for you. They can only give information to help with decision making.

How do you prefer to make medical decisions?

- ☐ I prefer to make medical decisions on my own without input from others.
- ☐ I prefer to make medical decisions only after input from others.
- ☐ I prefer to have other people make medical decisions for me.

If you want, you can write why you feel this way, and who you want input from.

What Matters Most in Life? Quality of life differs for each person.

What Is Most Important In Your Life? Check as many as you want.

- ☐ Your family or friends _____
- ☐ Your pets _____
- ☐ Hobbies, such as gardening, hiking, and cooking
  Your hobbies _____
- ☐ Working or volunteering _____
- ☐ Caring for yourself and being independent
- ☐ Not being a burden on your family
- ☐ Religion or spirituality: Your religion _____
- ☐ Something else _____

What brings your life joy? What are you most looking forward to in life?

Your Name

What Matters Most for your Medical Care? This differs for each person.

For some people, the main goal is to be kept alive as long as possible even if:

- They have to be kept alive on machines and are suffering
- They are too sick to talk to their family and friends

For other people, the main goal is to focus on quality of life and being comfortable.

- These people would prefer a natural death, and not be kept alive on machines

Other people are somewhere in between. **What is important to you?**

Your goals may differ today in your current health than at the end of life.

TODAY, IN YOUR CURRENT HEALTH

Put an X along this line to show how you feel today, in your current health.

My main goal is to live as long as possible, no matter what. | Equally Important | My main goal is to focus on quality of life and being comfortable.

If you want, you can write why you feel this way.

AT THE END OF LIFE

Put an X along this line to show how you would feel if you were so sick that you may die soon.

My main goal is to live as long as possible, no matter what. | Equally Important | My main goal is to focus on quality of life and being comfortable.

If you want, you can write why you feel this way.

Your Name

Quality of life differs for each person at the end of life. What would be most important to you?

AT THE END OF LIFE

Some people are willing to live through a lot for a chance of living longer.

Other people know that certain things would be very hard on their quality of life.

- Those things may make them want to focus on comfort rather than trying to live as long as possible.

At the end of life, which of these things would be very hard on your quality of life?
Check as many as you want.

- ☐ Being in a coma and not able to wake up or talk to my family and friends
- ☐ Not being able to live without being hooked up to machines
- ☐ Not being able to think for myself, such as severe dementia
- ☐ Not being able to feed, bathe, or take care of myself
- ☐ Not being able to live on my own, such as in a nursing home
- ☐ Having constant, severe pain or discomfort
- ☐ Something else _____

- ☐ **OR**, I am willing to live through all of these things for a chance of living longer.

If you want, you can write why you feel this way.

What experiences have you had with serious illness or with someone close to you who was very sick or dying?

- If you want, you can write down what went well or did not go well, and why.

If you were dying, where would you want to be?

☐ at home ☐ in the hospital ☐ either ☐ I am not sure

What else would be important, such as food, music, pets, or people you want around you?

Your Name

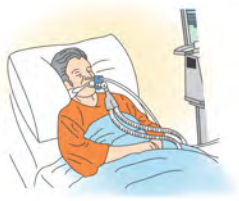
How Do You Balance Quality of Life with Medical Care?

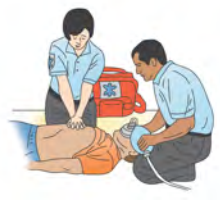
Sometimes illness and the treatments used to try to help people live longer can cause pain, side effects, and the inability to care for yourself.

Please read this whole page before making a choice.

AT THE END OF LIFE, some people are willing to live through a lot for a chance of living longer. Other people know that certain things would be very hard on their quality of life.

Life support treatment can be CPR, a breathing machine, feeding tubes, dialysis, or transfusions.





Check the one choice you most agree with.

If you were so sick that you may die soon, what would you prefer?

- ☐ **Try all life support treatments** that my doctors think might help. I want to **stay on life support** treatments even if there is little hope of getting better or living a life I value.

- ☐ Do a **trial of life support treatments** that my doctors think might help. But, I **DO NOT want to stay on life support** treatments if the treatments do not work and there is little hope of getting better or living a life I value.

- ☐ **I do not want life support treatments**, and I want to focus on being comfortable. I prefer to have a **natural death**.

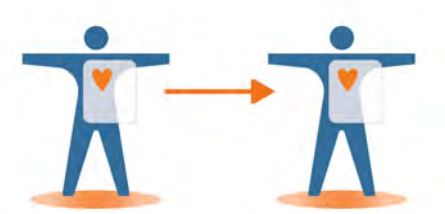
What else should your medical providers and decision maker know about this choice? Or, why did you choose this option?

Your Name

Your decision maker may be asked about organ donation and autopsy after you die. Please tell us your wishes.

ORGAN DONATION

Some people decide to donate their organs or body parts. What do you prefer?



- ☐ I **want** to donate my organs or body parts.

  Which organ or body part do you want to donate?

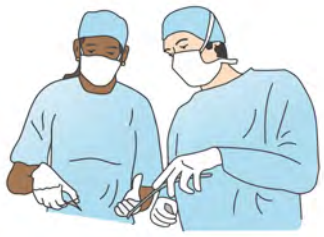
  - ☐ Any organ or body part
  - ☐ Only _____

- ☐ I **do not** want to donate my organs or body parts.

What else should your medical providers and medical decision maker know about donating your organs or body parts?

AUTOPSY

An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.



- ☐ I **want** an autopsy.
- ☐ I **do not** want an autopsy.
- ☐ I **only** want an autopsy if there are questions about my death.

FUNERAL OR BURIAL WISHES

What should your medical providers and decision maker know about how you want your body to be treated after you die, and your funeral or burial wishes?

- Do you have religious or spiritual wishes?
- Do you have funeral or burial wishes?

Your Name

What else should your medical providers and medical decision maker know about you and your choices for medical care?

Have you filled out other forms with your medical providers?

These forms may include a **Do Not Resucitate Order** or **POLST Form**.

If you do not know what these forms are, talk with your medical providers.

_____ Initial here if you filled out an Arizona Prehospital Medical Care Directive form (Do Not Resuscitate).

_____ Initial here if you filled out an Arizona POLST form.

If you have these forms, attach them to the end of this advance directive.

Your Name

Choose a Mental Healthcare Decision Maker

This section MUST be initialed in front of a witness or a notary. See Page 13.

- This person can make mental healthcare decisions for you if you are not able to make them yourself.
- They can be the same person as your medical decision maker in Part 1, or someone else.
- They cannot be your doctor or anyone who provides you medical care or mental healthcare.

Do you want your mental healthcare decision maker to be the SAME as your medical decision maker in Part 1, or someone DIFFERENT from your medical decision maker?
Initial the one choice you most agree with.

_____ Initial here, to allow your medical decision maker the power to make mental healthcare decisions for you. They would be both your medical decision maker and your mental healthcare decision maker.

OR

_____ Initial here, if you want your mental healthcare decision maker to be someone different from your medical decision maker in Part 1.

If DIFFERENT from your Medical Decision Maker in Part 1, write their name here.

first name last name

phone #1 phone #2 relationship

address city state zip code

If the first person cannot do it, then I want this person to make my mental healthcare decisions for me if I am not able to make my own:

first name last name

phone #1 phone #2 relationship

address city state zip code

This section must be initialed in front of a witness or a notary. See Page 13.

_____ Initial here, to allow your Mental Healthcare Decision Maker the power to admit you to an inpatient or partial psychiatric hospitalization program.

If there are mental health decisions you do not want them to make, write them here:

This section may not be revoked if you are not able to make decisions for yourself, as determined by your physician.

If you are done, you must sign this form on Page 13.

Your Name

Part 3 Sign the form

Before this form can be used, you must:

- sign this form if you are 18 years of age or older
- have one witness or a notary who can watch you sign this form
- if you chose a mental healthcare decision maker, one witness or notary must also watch you initial the form on Page 12a

Sign your name and write the date.

sign your name _____ today's date _____

print your first name _____ print your last name _____ date of birth _____

address _____ city _____ state _____ zip code _____

Witness or Notary

Before this form can be used, you must have 1 witness or a notary sign the form. The job of a notary is to make sure it is you signing the form.

Your witness must:

- be 18 years of age or older
- see you sign this form

Your witness cannot:

- be your medical or mental healthcare decision maker
- be your health care provider
- be related to you in any way
- benefit financially (get any money or property) after you die

Your witness needs to sign their name on Page 14.

If you chose a mental healthcare decision maker, one witness or notary must also watch you initial the form on Page 12a.

If you do not have a witness, a notary must sign on Page 15.

Have your witness sign their name and write the date.

By signing, I promise that _____ signed this form while I watched.
(the person named on Page 13)

They were thinking clearly and were not forced to sign it.

I also promise that:

- I am 18 years of age or older
- I am not their medical decision maker or their mental healthcare decision maker
- I am not their health care provider
- I am not related to them by blood, marriage, or adoption
- I cannot benefit financially (get any money or property) after they die

Witness

_____ _____
sign your name date

_____ _____
print your first name print your last name

_____ _____ _____ _____
address city state zip code

You are now done with this form.

Share this form with your family, friends, and medical providers. Talk with them about your medical wishes.

To learn more go to www.prepareforyourcare.org/go/azhha

Notary Public: Take this form to a notary public ONLY if one witness has not signed this form. Bring photo ID (driver's license, passport, etc.).

State of Arizona

County of _____

The foregoing instrument was acknowledged before me
this _____ day of _____, _____,
by _____ (person).

_____
NOTARY PUBLIC

_____
Print Name

My Commission expires _____

Arizona Prehospital Medical Care Directive (Do Not Resuscitate)

This form tells emergency medical technicians (EMTs) and/or hospital emergency room providers that you do not want CPR.

A Prehospital Medical Care Directive (Do Not Resuscitate) is a form signed by you and your medical provider if you make the decision you do not want CPR should your heart or breathing stop.

You may want to talk to your medical provider about this form if you are very ill, weak, and not expected to get better. If you decide to complete this form, EMTs and hospital emergency room providers will not use equipment, drugs, or CPR to start your heart or breathing. They will provide care to make you comfortable.

If you are healthy you may not wish to complete this form.

Must Do:

- This form must be signed by both your medical provider and you.
- This form must be on bright orange paper.
- Put this form on your refrigerator door so EMTs will see it in case of an emergency and give a copy to your hospital, if you have one.

If the Prehospital Medical Care Directive form is not attached to this document, ask to talk to your medical provider about it.

THIS FORM MUST BE PRINTED ON BRIGHT ORANGE PAPER!

Share this form with your medical decision maker, family, friends and medical providers.

Talk with them about your medical decisions.

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Arizona POLST

Arizona POLST is only for people who are seriously ill or frail. Unlike a healthcare directive, which is for future care, this form is for care now.

Completing this form is always voluntary.

The Arizona POLST is a form signed by you and your medical provider after talking about your serious illness and what treatments you want or do not want during a medical emergency. It offers more options than the Prehospital Medical Care Directive (Do Not Resuscitate) form.

Some of the choices include:

- CPR if your heart or breathing stops
- If you want to be put on a breathing machine
- If you want to be fed by a tube if you cannot swallow
- If you only want to be made comfortable.

The Arizona POLST form results in a medical order and follows you across different healthcare settings as part of your medical record.

Must Do:

- Have a conversation with your medical provider to make sure you understand your illness and what treatment options will help or not help you, so you can make informed decisions about your care.
- This form must be signed by both your medical provider and you.

If the POLST form is not attached to this document, ask to talk to your medical provider about it.

THE POLST FORM SHOULD BE PRINTED ON BRIGHT PINK PAPER.