

# The CRITICAL *Conditions*<sup>SM</sup> *Planning Guide*<sup>®</sup>

*A resource to help you and your loved ones  
discuss and make final health care decisions*

CRITICAL *Conditions*<sup>SM</sup>  
*Make your final health care decisions*



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# Getting Ready

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Imagine you are lying in a hospital bed unconscious and not able to speak for yourself. Decisions need to be made about medical treatments to prolong your life. How would your loved ones feel about having to make these decisions? Would they know what you want? Those who have faced this situation can tell you how hard it is. They will also tell you how much they wish they had known what their loved one wanted. Don't let this happen to your family. Talk to them about your final health care choices.

The CRITICAL *Conditions*<sup>SM</sup> Planning Guide will help. By completing the steps outlined in this booklet, you can prepare yourself and your loved ones to make these difficult decisions. Many of the issues raised in these materials may be hard for you to talk about. While the conversation will not always be easy, it is one of the most important discussions you will ever have.

## ***Here's how to get started:***

- Decide who should be part of your conversation. Include anyone who might have to make decisions for you when you can no longer make them for yourself. This could be your spouse, your adult children, a parent, another relative or a friend.
- Schedule a time when you will not be interrupted for at least an hour. Be prepared to spend more time if needed. You may find that you want to have this conversation over a period of days or even weeks. These are critical issues, and your decisions should not be rushed.
- Choose a comfortable setting for the conversation. Privacy may be important as well, since this topic can evoke strong emotions.

Now you are ready to go through the other parts of the Planning Guide. They include:

***Step 1 – The Conversation Starter.*** The Conversation Starter describes a number of conditions that require decisions about providing, withdrawing, or withholding medical treatments. Each case is followed by questions for you to discuss. After talking about these cases, you will have a better understanding of the final health care you and your loved ones want.

***Step 2 – The Individual Worksheet.*** Use the Individual Worksheet to begin making decisions about the medical treatments you want for yourself at the end of life. The Individual Worksheet is *not a legal document*. However, it can serve as a guide for your loved ones if they have to make decisions for you. Completing the worksheet will prepare you to execute the legal document called the Georgia Advance Directive for Health Care, Step 3.

***Step 3 – The Georgia Advance Directive for Health Care.*** This document is the legal format for expressing your wishes. *You do not have to use a lawyer to complete the form.* If you follow the directions in the document, it will be legal in Georgia. The Georgia Advance Directive for Health Care lets you do two things:

- legally appoint someone to make health care decisions for you when you cannot or do not want to speak for yourself, and
- formally state your preferences for the medical treatments you do or do not want to receive.

**The “What to Do Now” section** gives suggestions for distributing your Georgia Advance Directive for Health Care and other ways to ensure that your wishes are followed. There are two important things you should know:

- You can always change your mind about the care you want by revoking, destroying or updating your Georgia Advance Directive for Health Care.
- As long as you can speak for yourself, your Georgia Advance Directive for Health Care does not take effect.

*In taking these steps, you will give your loved ones a great gift – the peace of mind in knowing your wishes!*



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# Step 1 – Conversation Starter

You are taking an important step in preparing yourself and your loved ones to make crucial decisions about your health care. Letting your loved ones know your views is the best way to make sure your wishes are followed.

The Conversation Starter raises a number of issues which you need to discuss. The issues are presented in stories followed by a few questions. The stories describe specific situations that could happen to you or to a loved one. The questions will help you think through your feelings and attitudes. The information boxes below the questions provide definitions and other data related to the topic being discussed. Be sure to read the information boxes before you discuss the questions.

You do not have to talk about all of the questions or complete all the stories at one time. Go at your own pace. This is just a guide. Each family will want to talk about these issues in its own way. The main thing is to start thinking and begin talking. Keep in mind that there are no wrong or right answers to these questions. Your loved ones' points of view may be different from yours. You shouldn't feel you have to agree. Simply try to understand and respect each other's opinions. It is important to include all those who might have to make decisions for you in this conversation, so that everyone will know and understand your wishes.

*At this point, you just want to talk. Don't write down your answers to the questions.* You will record your wishes when you get to Step 2 – The Individual Worksheet. You may need more information or want other opinions before you are ready to make your decisions. You may choose to talk to your doctor, lawyer or spiritual advisor.

Begin your conversation by reading the story about Sam, and see if you share his concerns about having a serious illness. After reading his story, move on to the questions. Read each question aloud and allow each person to answer. Discuss your answers by asking why someone feels a certain way. When everyone has had a chance to talk, move on to the next story and repeat the same process. As you go through the stories, try not to limit your discussions to the person described in the case. *Use the story to imagine yourself or a loved one in a similar situation.* Think about what you want for yourself. You and your loved ones might have different ideas about the medical treatments you want. What is important in Step 1 is that you understand what each person involved in your conversation wants for himself or herself.

***Above all, remember that your wishes can't be followed if no one knows what they are.***

# General Concerns

Sam, age 44, has just been told he has a serious illness that will cause his health to deteriorate slowly. Because there is no cure for his illness, Sam will eventually die. However, there are treatments that can help Sam live longer. In thinking about his illness, Sam is anxious about his future and is concerned about the cost of his treatment. Because he has a strong faith, Sam is not afraid to die. However, he has never talked about his death or thought about what kind of health care he wants. He is concerned about how his illness and death will affect his loved ones.

*You may find that your religious views, financial and family concerns, and attitudes about quality of life\* play a part in how you feel about many different medical situations. Keep the conversation you have about the following questions in mind as you go through the rest of the guide. You will probably refer back to these views in a number of instances.*

## **Discussion Questions:**

- 1.** Are you reluctant to talk about the prospects of your own death? Why?
- 2.** Do you have religious, spiritual or moral beliefs that play a part in how you feel about extending life with medical treatments? What are these views?
- 3.** Would concerns about money play a part in making your decisions about medical care? In what way?
- 4.** Would you be concerned about being a burden to your loved ones if you were *terminally ill*\*? If so, in what way? How do you think your loved ones would feel?
- 5.** Would being aware, being free of pain, remaining independent, or other issues about *quality of life*\* play a part in making decisions about your medical care? How?
- 6.** How would having to make decisions about your care affect your loved ones? Would they know what you want?

### **\* Terminal Condition**

An incurable or irreversible condition caused by disease, illness or injury which will lead to death in a relatively short period of time.

### **\* Quality of Life**

The features of an individual's life that give his/her life personal meaning and value.

# Your Views on Prolonging Life

Don and Judy are a married couple in their mid 50s. Both are in good health. They have three children and two grandchildren. Judy's mother has recently died after a long illness. Because of this, Don and Judy have decided to write down their preferences for the kind of medical care they want to receive if they become critically ill or injured with little hope of recovery.

Don has decided that he does not want any treatments that would prolong his life. Rather, he only wants *comfort care*\* to ease his pain. He says he would want to live as normally as possible during his last months of life. He does not want to be in and out of hospitals or try treatments that might cause him to feel sick all of the time. Don says he absolutely does not want to be put on any type of machine to keep him alive.

Judy feels differently. She wants to stay alive as long as possible. Judy says that new treatments and cures are discovered every day. By having life-prolonging treatments, Judy thinks she may stay alive long enough to benefit from some new cure.

## Discussion Questions:

1. Do you feel more like Don or Judy about prolonging your life with medical treatments? Why do you feel the way you do?
2. If you are more like Don, would you ever want to try medical treatments to help prolong your life? Under what conditions?
3. If you are more like Judy, would you ever want to stop medical treatments? Under what conditions?
4. Would age matter in how far you want to go to prolong your life, or do you feel that age should not be considered when making these decisions?
5. Would you discuss your feelings about life-prolonging treatments with your doctor? Why or why not?

### \* *Comfort Care*

Care to keep patients as comfortable as possible when they are terminally ill. This type of care includes pain medication, moistening the lips, giving food and fluids by mouth, oxygen, turning the body to prevent bed sores, bathing, tending to bladder and bowel functions. Comfort care also includes many of the emotional, psychological, and spiritual issues that affect terminally ill patients and their families. It can occasionally include surgery. Comfort care eases the dying process but does not slow it down.

### *Your Right to Decide*

You have a legal right as a competent adult\* to consent to or refuse needed medical care. To exercise this right, you must communicate your choices in a clear, convincing way to your loved ones and/or health care providers. Both verbal and written directions can be used to express your wishes.

### \* *Competent Adult*

If you have not been determined to be incompetent by a court, you are assumed to be competent.

# Cardiopulmonary Resuscitation (CPR)

At age 76, Roger had a major stroke that left him partially paralyzed. He is unable to walk and has difficulty talking. He cannot feed himself or take care of any of his own bodily functions. He is able to understand what is going on around him and can make his own decisions. However, Roger has no one to take care of him. He is going to a nursing home where he can get the care he needs 24 hours a day. While being admitted, Roger is asked whether or not he would want to receive *Cardiopulmonary Resuscitation (CPR)*\* if he stops breathing or his heart stops beating. If Roger decides he does not want CPR, the doctor at the nursing home will write a *Do Not Resuscitate (DNR)* or *Allow Natural Death (AND)*\* order. Roger may also request not to be transferred\* to a hospital in the case of an emergency. Instead, he would be allowed to die in the nursing home. If Roger decides he does want CPR, he will be transferred to a hospital for treatment whenever he has a health crisis.

## Discussion Questions:

1. If you were in Roger's situation, would you want to receive CPR? Why or why not?
2. Would you have any concerns about refusing CPR? For instance, would you be afraid that other treatments would be withheld?
3. How would you feel about having to make a decision about CPR for a loved one who was ill and could not communicate?
4. If Roger were your loved one, would you know if he had a written document outlining his health care choices? Would you know where to find this document?
5. If you were in Roger's condition and you were found unconscious in your home, would you want to receive emergency treatments such as CPR?

### \* *Cardiopulmonary Resuscitation (CPR)*

The act of reviving someone whose heart and/or breathing have stopped. Medical procedures involved with CPR include electric shock, pushing on the chest, administering drugs, or putting a tube attached to a breathing machine through the mouth or nose into the windpipe. Upon admission to a hospital or nursing home, it is assumed that every patient whose heart stops beating will receive CPR.

*40 to 50 percent of hospitalized patients who receive CPR survive initially, but only 15 to 20 percent live long enough to be discharged from the hospital. Sick elderly patients have less than a 5 percent chance of survival to discharge after CPR.*

### \* *Do Not Resuscitate (DNR)*

### \* *Allow Natural Death (AND)*

A doctor's order in your hospital or nursing home chart that says you do not want to be revived if your heart or breathing stops. In Georgia you may keep your *DNR/AND* status after you are discharged from a hospital to your home by wearing an orange armband or necklace. You will need to ask your doctor to provide you with this armband.

### \* *Do Not Transfer*

A doctor's order in your nursing home chart that says you do not want to be transferred to a hospital if you stop breathing or your heart stops.

# Receiving Food and Water Through a Tube

Simone is 28 years old. She has a husband and two young children. As a result of a car accident, she has severe brain damage and is in *a state of permanent unconsciousness\** sometimes called a persistent vegetative state. The doctors have told Simone's family that it is highly unlikely that she will ever regain consciousness. Because she is young and otherwise healthy, Simone could live a number of years if she is given food and water through a tube which is surgically placed in her stomach (known as *artificial hydration and nutrition\**).

## Discussion Questions:

1. If you were in Simone's condition, would you want to be kept alive by receiving food and water through a tube?
2. Would you want to receive fluids through a vein but not want to receive food through a stomach tube? Why or why not?
3. Do you feel differently about removing a feeding tube than you do about inserting the tube in the first place?
4. Can you think of situations when it would be important for you to receive food and water through a tube? Can you think of situations when you would **not** want to receive food and water through a tube? What situations?
5. How much time would Simone need to be in this condition before you could make the decision about a feeding tube?

### \* *State of Permanent Unconsciousness*

A state of permanent unconsciousness is an incurable or irreversible condition in which you are not aware of yourself or your surroundings and where you show no behavioral response to your surroundings.

*A state of permanent unconsciousness can be judged to be permanent 12 months after a traumatic injury. Recovery after this time is very rare and almost always involves a severe disability.*

### \* *Artificial Nutrition*

A tube placed in the nose or mouth or surgically placed in the stomach to provide food when a person cannot eat normally.

### \* *Artificial Hydration*

A needle or tube used to provide water and other fluids when a person cannot drink normally.

*Without fluids, death occurs in approximately 3 to 14 days. Most medical evidence indicates that dehydration in the end stage of a terminal illness is a very natural and compassionate way to die. In seriously ill or dying patients, lack of fluids causes sleepiness and unconsciousness, making the person unaware of the dying process.*

# Living on a Breathing Machine

George is 62 and has suffered for many years from a lung disease that makes breathing hard. One day a friend finds George unconscious and not breathing. The friend calls for an ambulance, and George is revived at the emergency room. He is put on a breathing machine known as a *ventilator or respirator*.\* The doctors say George has brain damage\* from loss of oxygen. He will die if he is taken off the breathing machine. He may or may not regain consciousness, but he could live for many years with help from the breathing machine.

## Discussion Questions:

1. Would you want to be placed permanently on a breathing machine in order to live? Why or why not?
2. Could you make the decision to remove a loved one from a breathing machine if it would surely end his or her life?
3. Do you feel differently about removing George from the breathing machine than you do about connecting George to the machine?
4. If you were in George's situation would your loved ones know if you want to be permanently placed on a breathing machine?
5. If a loved one other than your spouse (a sibling, adult child, parent, etc.) were in George's condition, would you know what he or she wants?

### \* Ventilators/Respirators

Machines that breathe for a person if lung function is inadequate. A tube is inserted into the windpipe through the nose or mouth or through a hole cut in the front of the neck.

*\*Brain function is measured by electrical activity in the brain. To be considered "brain dead" requires irreversible cessation of all functions of the entire brain, including the brain stem. A person who is brain dead would have a total absence of responsiveness, reflexes, and electrical activity.*

# Having an Incurable Brain Disease

Katherine is in her late 70's. For the past ten years she has slowly lost her ability to take care of herself because she has an incurable brain illness known as *Alzheimer's Disease*,\* (sometimes called Old Timer's Disease). Physically she is in good health and is not in pain, but Katherine no longer recognizes her family and friends and cannot carry on a conversation. She spends her days either sitting and staring into space or roaming aimlessly around the nursing home where she lives. Katherine has come down with pneumonia. If she is given medicine, Katherine will recover from the pneumonia. If her pneumonia is not treated, Katherine will die.

## Discussion Questions:

1. If you were in Katherine's condition, would you want to be given medicine to treat the pneumonia?
2. What concerns would you have about not treating Katherine's pneumonia, if you had to make this decision for a loved one?
3. Some health conditions may require that a person with an incurable brain disease, or any other incurable illness, have different treatments in order to

prolong life or delay death. These treatments could be *chemotherapy*,\* *transfusions*,\* *kidney dialysis*,\* or surgery. How would you feel about having these treatments if you had an incurable illness?

4. If you had an incurable brain disease, would you want to receive medical treatment if you had another illness that could cause your death? Is there any medical treatment that you would not want to receive?

### \* *Alzheimer's Disease*

An incurable brain disease marked by loss of memory and other mental capacities over a period of time. The disease is relentless and irreversible. It can take a patient a few months to several years to reach a state of complete helplessness.

### \* *Chemotherapy Treatments*

Chemotherapy is a drug treatment for cancer. It often causes nausea, vomiting or serious complications. Chemotherapy can sometimes temporarily reduce the discomfort of cancer, even if it does not always cure it.

### \* *Transfusion*

Receiving blood or blood products through a needle placed in the vein.

### \* *Kidney Dialysis*

A machine used to cleanse the blood when the kidneys cannot function normally. When kidneys fail, dialysis will be permanently required several times a week, unless a transplant is performed.

# Managing Pain

Fred, 84, is dying from a long-term illness and is worried about pain. He wants as much pain medication as possible to relieve his suffering. Fred's doctor has said that pain medication can have side effects. He explained to Fred that pain medicine could make him groggy or even unconscious and unable to talk to his family and friends.

## ***Discussion Questions:***

- 1.** How do you feel about pain and pain medications?
- 2.** If you had an illness that caused you a lot of pain over many months, would you be concerned about taking medications such as narcotics or opioids\* to control your pain? Why or why not?
- 3.** Would you rather be more conscious and have some pain or have less pain and be groggier?

*A study of terminally ill patients determined that 50 percent of those dying in hospitals experienced moderate or severe pain at least half the time during their last days.*

### **\* Opioids**

*Medications such as morphine given to patients in order to control severe pain.*

# Organ Donation

Chris, 57, was playing golf when he passed out on the fairway. A call was placed to 911, and Chris was taken by ambulance to the nearest emergency room. Unfortunately, he never regained consciousness. At the hospital, Chris was placed on a breathing machine. Doctors determined that there was no blood flowing to Chris' brain and that he was brain dead. At this time, his family was asked to consider donating Chris' organs for transplant. The family decided to donate any organs and tissues he was suitable to give.

## Discussion Questions:

1. Would you want to be an organ donor?  
Why or why not?
2. How would you feel if your family were faced with making a decision about organ donation in a situation like this?
3. Have you shared your wishes about organ, tissue and/or eye donation with family members? How?
4. How would you feel if you or a loved one needed an organ transplant?
5. If you were not able to donate organs for transplant, would you want to donate your body for research or medical education? Why or why not?

*Organs that can be donated are the heart, lung, kidney, pancreas, liver and small intestine. Tissues that can be donated include bone, skin and heart valves.*

*For more information about organ donation, call 1-800-544-6667. For eye donation information, call 1-800-342-9812.*

*Arrangements for donating your body for research and education must be made in advance. If you choose to donate your body you cannot be an organ donor. For information contact a medical school in your area.*

*In Georgia, you can indicate on your driver's license that you want to be an organ donor.*

*To be successfully transplanted, organs must continue to receive blood until they are removed from the body of the donor. For this reason, it will be necessary to keep the donor on a breathing machine.*

# Thoughts About Your Death

At age 53, Colette has a terminal condition and is nearing death. She has decided that she would like to die at home. She wants to be with her family and be free to do what she wants in her last days. But Colette is worried that as she gets worse, her husband will not be able to take care of her. She has no one else to help out. She has decided to get help from a *hospice*\* service that can provide the medical help she needs and give her husband emotional support as well.

## Discussion Questions:

1. Have you experienced the death of a relative or close friend? How do you feel about the way this person died? Would you want your death to be different? How?
2. If you could make the choice, where would you like to die? Why there?
3. Would you like someone to be with you when you die? Who?
4. Would you like any special activities to occur at your death, such as having music play or people pray? Describe.
5. Are you familiar with hospice services? What do you think about hospice as an alternative to dying in a hospital?
6. What do you want to be done with your body after you die? Do you want to be buried or cremated? Have you thought about the kind of funeral or memorial you would want?

### \* *Hospice*

Hospice is a program of comfort care and support services provided to dying patients and their families. Hospice services are primarily provided in the home, but hospice facilities are available in some areas. Hospice provides medical care to relieve pain and suffering as well as emotional and spiritual support for the patient and family members.

# Who Should be the One to Make Decisions for You If You Cannot?

Vera's husband recently had a heart attack and died suddenly. Vera, 67, lives in south Georgia where she, her parents and her grandparents grew up. She has two sisters who are several years younger and live nearby. Her two grown children have moved out of state and will probably never come back to Georgia to live. Since her husband died, Vera is worried about who will make medical decisions for her if she gets too sick to make them for herself. She has decided to appoint someone legally to make these decisions. She is concerned that her children live too far away to help if an immediate decision needed to be made. She also knows that one of her children would follow her wishes, but the other would not. Because she doesn't want to cause conflict between her children, Vera has decided to appoint one of her sisters to have the legal authority to make decisions for her. This person is called a *Health Care Agent*.\*

## Discussion Questions:

1. Who would you want to make medical decisions for you if you could not make them for yourself? Why would this person be a good choice to make decisions for you?
2. Does this person know what medical treatments you do or do not want? Would he or she be able to follow your wishes?
3. What kinds of decisions would you want this person to be able to make for you? Would you want to place any limits on the decisions he or she could make? What would those limits be?
4. Do you think having to make decisions about prolonging your life would cause conflicts among your loved ones? If so, how could you help resolve this conflict?

### \* *Health Care Agent*

A person who decides about your health care when you cannot decide for yourself. You can appoint your own Health Care Agent by completing a Georgia Advance Directive for Health Care. It is always good to appoint a second person as a back-up in case your Agent is not available when he or she is needed.



# Step 2–Individual Worksheet<sup>®</sup>

When you are ready to make decisions about your final health care, use this worksheet to help you think through your choices. The form can be easily removed so that you can make copies for the other members of your family. Each person should complete his or her own Individual Worksheet. Although you may want to discuss the questions with your loved ones, the completed worksheet should reflect *your* feelings and values. Your worksheet can serve as a guide to your loved ones if they ever have to make health care decisions for you. Completing this worksheet will prepare you to complete the legal document in Step 3, The Georgia Advance Directive for Health Care.

## *This is the Individual Worksheet of:*

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

## *Copies of this document have been given to:*

1: \_\_\_\_\_  
*(Provide complete name, address and phone number)*

2: \_\_\_\_\_  
*(Provide complete name, address and phone number)*

3: \_\_\_\_\_  
*(Provide complete name, address and phone number)*

4: \_\_\_\_\_  
*(Provide complete name, address and phone number)*

## Making Decisions About My Care

Refer to Conversation Starter, page 5.

### 1. In making decisions about my medical care, the following reflect my views:

*(Check Your Responses)*

- |   |                              |                             |                                    |
|---|------------------------------|-----------------------------|------------------------------------|
| a. I want to prolong my life by any means possible:         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| b. I want to control pain and suffering:                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| c. I want a quality of life consistent with my values:      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| d. I want to keep from being a burden to my family/friends: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| e. I want to save my family's money:                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| f. I want to act according to my religious beliefs:         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |

My religion is: \_\_\_\_\_

### 2. Other things that are important to me in making these decisions are:

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## Defining My Quality of Life

Refer to Conversation Starter, page 4.

### 3. The things that make my life worth living are:

*(Check Your Responses)*

- |   |                              |                             |                                    |
|---|------------------------------|-----------------------------|------------------------------------|
| a. Thinking well enough to make everyday decisions:             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| b. Being able to take care of myself (bathing, dressing, etc.): | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| c. Communicating with and relating to others:                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| d. Being conscious and aware of what is happening around me:    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| e. Being comfortable and free of pain:                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| f. Living independently without aid of life-support machines:   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| g. Being able to move about:                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| h. Knowing my family and friends:                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Undecided |
| i. Engaging in the following activities:                        |                              |                             |                                    |

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### 4. These things are important to me because:

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## Receiving Treatments If I Have an Incurable Illness

Refer to Conversation Starter, pages 6-8.

**5. If I have an *incurable illness* which will *most probably cause my death*, and I can no longer speak for myself:**

*(Check one)*

I want to try any medical treatment to prolong my life for as long as possible.

**OR**

I want to try medical treatments for a reasonable period of time, but I will probably want treatments other than those to control pain to be stopped if my condition does not improve.

**OR**

I only want pain medicine and other treatments to make me comfortable. I do not want to spend my last months having medical treatments that have no hope of curing my illness.

**OR**

I am undecided at this time.

**6. I chose this approach because:**

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**7. If I am in the final stages of an illness that *cannot be cured*, such as cancer, and I also have another illness that can be cured, and I can no longer speak for myself:**

*(Check Your Responses)*

**a.** I want to receive medications and/or treatments for the illness that can be cured:

Yes     No     Undecided

**b.** I want any surgery necessary to treat the illness that can be cured:

Yes     No     Undecided

**8. I made this choice because:**

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9. If I am in the final stages of an illness that *cannot be cured*, and that will *most probably cause my death*, and I can no longer speak for myself, I want:

Check <i>one</i> response for each treatment				
	Yes	No	Try, but if no clear improvement, stop treatment	Undecided at this time
a. A tube placed in my nose or mouth and connected to a machine to breathe for me:			(check one) <input type="checkbox"/> Try for a few days <input type="checkbox"/> Try for a few weeks <input type="checkbox"/> Try for a few months	
b. A tube placed in my nose or mouth, or surgically placed in my stomach, to give me food:			(check one) <input type="checkbox"/> Try for a few days <input type="checkbox"/> Try for a few weeks <input type="checkbox"/> Try for a few months	
c. A needle or catheter placed in my body to give me water and other fluids:			(check one) <input type="checkbox"/> Try for a few days <input type="checkbox"/> Try for a few weeks <input type="checkbox"/> Try for a few months	
d. Medications such as antibiotics to fight infections:				
e. Techniques used to bring a person back to life when breathing and pulse have stopped (Cardiopulmonary Resuscitation/CPR):				
f. To receive blood or blood products through a needle placed in my body (transfusions):				
g. My blood cleansed by a machine if my kidneys fail (kidney dialysis):				
h. Surgery to help prolong my life/delay my death:				
i. To receive emergency treatment if I am found unconscious in my home:				
j. To receive hospice care:				
k. Other:				

### ***Receiving Treatments If I Have an Incurable Brain Disease***

Refer to Conversation Starter, page 9.

10. If I have a *brain disease that cannot be reversed*, and I cannot recognize my family and friends, speak meaningfully to them, or live independently:

- a. I want to receive any medical treatment for the brain disease that could prolong my life:
  - Yes
  - No, but I would want to receive pain medicine and other comfort care.
  - Undecided

- b. I want to be treated for any other illness that could cause my death:
- Yes
  - No, but I would want to receive pain medicine and other comfort care.
  - Undecided

**11. I made these decisions because:**

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**12. If I have a *brain disease that cannot be reversed* and I cannot recognize my family and friends, speak meaningfully to them, or live independently, I want:**

Check <i>one</i> response for each treatment				
	Yes	No	Try, but if no clear improvement, stop treatment	Undecided at this time
a. A tube placed in my nose or mouth and connected to a machine to breathe for me:			(check one) ___ Try for a few days ___ Try for a few weeks ___ Try for a few months	
b. A tube placed in my nose or mouth, or surgically placed in my stomach, to give me food:			(check one) ___ Try for a few days ___ Try for a few weeks ___ Try for a few months	
c. A needle or catheter placed in my body to give me water and other fluids:			(check one) ___ Try for a few days ___ Try for a few weeks ___ Try for a few months	
d. Medications such as antibiotics to fight infections:				
e. Techniques used to bring a person back to life when breathing and pulse have stopped (Cardiopulmonary Resuscitation/CPR):				
f. To receive blood or blood products through a needle placed in my body (transfusions):				
g. My blood cleansed by a machine if my kidneys fail (kidney dialysis):				
h. Surgery to help prolong my life/delay my death:				
i. To receive emergency treatment if I am found unconscious in my home:				
j. Other:				

## Receiving Treatments If I Am In a State of Permanent Unconsciousness

Refer to Conversation Starter, page 7.

13. If I am in a state of permanent unconsciousness and it is *highly unlikely* that I will ever wake up, I want:

	Check <i>one</i> response for each treatment			
	Yes	No	Try, but if no clear improvement, stop treatment	Undecided at this time
a. A tube placed in my nose or mouth and connected to a machine to breathe for me:			(check one) <input type="checkbox"/> Try for a few days <input type="checkbox"/> Try for a few weeks <input type="checkbox"/> Try for a few months	
b. A tube placed in my nose or mouth, or surgically placed in my stomach, to give me food:			(check one) <input type="checkbox"/> Try for a few days <input type="checkbox"/> Try for a few weeks <input type="checkbox"/> Try for a few months	
c. A needle or catheter placed in my body to give me water and other fluids:			(check one) <input type="checkbox"/> Try for a few days <input type="checkbox"/> Try for a few weeks <input type="checkbox"/> Try for a few months	
d. Medications such as antibiotics to fight infections:				
e. Techniques used to bring a person back to life when breathing and pulse have stopped (Cardiopulmonary Resuscitation/CPR):				
f. To receive blood or blood products through a needle placed in my body (transfusions):				
g. My blood cleansed by a machine if my kidneys fail (kidney dialysis):				
h. Surgery to help prolong my life/delay my death:				
i. Other				

## Receiving Pain Medications

Refer to Conversation Starter, page 10.

**14. If I have a terminal illness or injury and there is *little or no chance* that I will ever be well again, and I can no longer speak for myself, I want to receive enough medicine to relieve my pain even though:**

*(Check Your Responses)*

- a. The drugs I am taking may cause me to be less conscious and unable to talk:  Yes  No  Undecided

**15. The reasons I have made these decisions about pain medications are:**

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## Donating My Organs

Refer to Conversation Starter, page 11.

**16. After I am dead:**

*(Check Your Responses)*

- a. I want my organs donated to help save or improve someone else's life:  Yes  No  Undecided
- b. I want my tissues donated to help save or improve someone else's life:  Yes  No  Undecided
- c. I want my eyes donated to help improve someone else's life:  Yes  No  Undecided
- d. I want my body donated for the purposes of medical education or research (Organ and tissue donation not possible with this option):  Yes  No  Undecided

## Choosing My Health Care Agent

Refer to Conversation Starter, page 13.

**17. It is important that the person who makes decisions about my medical treatments when I can no longer speak for myself be someone:**

*(Check Your Responses)*

- a. I love and trust:  Yes  No  Undecided
- b. Who knows me very well:  Yes  No  Undecided
- c. Who is not emotionally attached to me:  Yes  No  Undecided
- d. Who lives near me:  Yes  No  Undecided
- e. Who has discussed my wishes with me:  Yes  No  Undecided
- f. Other conditions important to me are:

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**18. In thinking about my loved ones and the decisions I have made for my final health care, I think they will:**

**(Check One)**

- Agree with and carry out my decisions.
- Disagree with but carry out my decisions.
- Disagree with and not carry out my decisions.
- Disagree with each other about whether or not to carry out my decisions.
- Not know what my wishes are.

**19. The people I want to be my Health Care Agent and back-up Health Care Agents are:**

Name(s)	Reason(s)
1st. _____	_____
2nd. _____	_____
3rd. _____	_____
4th. _____	_____
5th. _____	_____

**20. When I am no longer able to speak for myself, I want my Health Care Agent to:**

*(Check Your Responses)*

- a. Make choices for me about my medical care:  Yes  No  Undecided
- b. Communicate my wishes to my doctor:  Yes  No  Undecided
- c. Arrange for hospital, hospice or nursing home care for me:  Yes  No  Undecided
- d. See any of my medical records and personal files:  Yes  No  Undecided
- e. Apply for Medicare, Medicaid or other programs or insurance for me:  Yes  No  Undecided
- f. Decide about the disposition of my body:  Yes  No  Undecided
- g. Authorize an autopsy, if necessary:  Yes  No  Undecided
- h. Discuss decisions about my care with other family members:  Yes  No  Undecided
- i. Other:

\_\_\_\_\_

\_\_\_\_\_

**21. When I can no longer speak for myself, I would like the following to be the final determination of what I would want:**

**(Check One)**

- a. My preferences as I have written them down.
- b. My preferences as I have discussed them with \_\_\_\_\_.
- c. Decisions made by my Health Care Agent.
- d. Decisions made by the doctors who are treating me at the time.
- e. Other: \_\_\_\_\_.

## About My Death

Refer to Conversation Starter, page 12.

### 22. If I have a choice, I want to die:

**(Check One)**

- a. in a hospital
- b. in my home
- c. in a hospice facility
- d. in a nursing home
- e. undecided at this time
- f. other: \_\_\_\_\_

### 23. The reasons I want to die there are:

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### 24. When I die, I want to have these people with me, if possible:

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### 25. My other preferences about my death include:

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### 26. If there is a choice, I would consent to an autopsy of my body if my doctor or my Health Care Agent thinks it is necessary:

- Yes    No    Undecided

### 27. After my death I want my body to be:

**(Check One:)**

- a. buried    b. cremated    c. undecided

## Signature

I completed this worksheet outlining my preferences for my final health care on the date indicated below:

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date Completed

***Reviewing My Individual Worksheet***

I want my family to use this Individual Worksheet as an indication of my preferences. So that they will know that it continues to reflect my feelings accurately, I have reviewed this document and confirmed my preferences by signing it again on the dates indicated below.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



**EMORY**  
CENTER FOR  
ETHICS



# Step 3—Georgia Advance Directive for Health Care

In order to have a legal document that expresses your wishes for the health care you want to receive at the end of your life, you should complete a Georgia Advance Directive for Health Care. In completing the Georgia Advance Directive for Health Care, you will do two things:

- legally appoint someone as your Health Care Agent to make health care decisions for you when you cannot or do not want to speak for yourself, and
- formally state your preferences for the medical treatments you do or do not want to receive.

## Things You Should Know

- You do not need to hire a lawyer to complete a Georgia Advance Directive for Health Care. The document includes instructions on how to complete the form. However, you are encouraged to consult your lawyer, doctor, or other professionals to help you make informed decisions.
- As a competent adult, you have the right to refuse any unwanted treatments or procedures for any reason, even treatments that could keep you alive (unless you are pregnant with a viable fetus).
- The Georgia Advance Directive for Health Care covers only health care decisions. *It has no effect over financial affairs that are unrelated to your health care.*
- You or your Health Care Agent are responsible for notifying your doctor and other health care providers that you have a Georgia Advance Directive for Health Care.
- If you choose not to complete a Georgia Advance Directive for Health Care, there may be restrictions on the health care decisions that relatives or friends can make for you.
- If a doctor or other health care provider has direct knowledge of your preferences as documented in your Georgia Advance Directive for Health Care or expressed by your Health Care Agent, he is required to abide by your preferences as long as your preferences are legal. If the doctor or health care provider is unwilling to honor your preferences, he must assist in transferring your care to another provider.
- Georgia law protects a doctor or health care provider who, in good faith, follows your preferences as documented in the Georgia Advance Directive for Health Care or directed by your Health Care Agent.
- It is against Georgia law for any person willfully to hide, cancel or alter another person's health care directive, its amendments or cancellation.
- Another person can complete a Georgia Advance Directive for Health Care for you but only with your expressed consent and in your presence. Once you have been determined to be incapable of making your own decisions, you cannot complete a Georgia Advance Directive for Health Care, nor can someone else complete one for you.
- A hospital, nursing facility, home health company, or hospice program cannot refuse to admit you because you do not have a Georgia Advance Directive for Health Care.
- Completing a Georgia Advance Directive for Health Care will have no effect on your ability to buy, pay

premiums on, or collect on any type of insurance, including health, life, and disability insurance. You cannot be required to have a Georgia Advance Directive for Health Care in order to obtain health insurance.

- The laws on honoring health care directives differ from state to state. Because the Georgia Advance Directive for Health Care you complete in Georgia expresses your preferences about medical care, it will influence that care no matter where you are treated. However, there is a possibility that this Georgia Advance Directive for Health Care may not be honored in another state. If you spend a great deal of time in another state, you may want to complete a document that meets all the requirements of that state.
- If you have an emergency and your Georgia Advance Directive for Health Care is not readily available, life sustaining treatments may be started. Treatment can be stopped if it is discovered that it is not what you want.
- The Georgia Advance Directive for Health Care is not connected to any government health care program, such as Medicare or Medicaid. Any competent adult may complete a Georgia Advance Directive for Health Care regardless of how they pay for their health care.
- The Georgia Advance Directive for Health Care allows you to appoint a Health Care Agent – this is a person who will have the legal power to make decisions regarding your health care – but ONLY when you are *incapable* of making those decisions yourself or choose not to make your own decisions. You may be *incapable* of making your own decisions because you are unconscious, mentally ill, in a coma, in the advanced stages of Alzheimer’s Disease or are otherwise unable to make your own decisions. *You do not have to be terminally ill or near death for your Health Care Agent to be able to make decisions for you, but you must be incapable*

*of making your own decisions or choose not to make your own decisions.*

- Georgia law protects your Health Care Agent as long as he or she acts in “good faith” and in accordance with your instructions.
- Your Health Care Agent cannot be held responsible for the cost of your medical care. However, if you have named your spouse as your Health Care Agent, your spouse may be responsible for the cost of your medical care because he or she is your spouse.
- A change in your marital status may revoke the appointment of your Health Care Agent.
- The Georgia Advance Directive for Health Care also will give you the option to nominate someone to serve as your *guardian*. A court may appoint a guardian if it determines that you are not able to make significant responsible decisions for yourself. You may nominate the same person you designated as your Health Care Agent to serve as your guardian. However, if you chose to nominate someone else to be your guardian, you should be aware that the person named as your Health Care Agent would have priority over your guardian in making your health care decisions, unless a court determines otherwise.
- The person you name as your Health Care Agent will have broad powers to make health care decisions for you, including the power to require, consent to, or withdraw any type of personal care or medical treatment for any physical or mental condition.
- Your Health Care Agent can agree to admit or discharge you from any hospital, nursing home, or other institution.
- Georgia law does not allow your Health Care Agent to put you in a mental hospital against your will or to make decisions about sterilization or psychosurgery.

- The law does not require the person you name as your Health Care Agent to act for you. You must ask that person if he or she is willing to accept this responsibility.
- Your Health Care Agent must use due care to act for your benefit and in accordance with your Georgia Advance Directive for Health Care.
- A court can take away the powers of your Health Care Agent if it finds that your Agent is not acting according to your preferences or that your Agent is not competent to make decisions.
- You may appoint a Health Care Agent as well as one or more back-up Agents, in case your primary Agent is not available when decisions need to be made.
- You can choose anyone who is over 18 years of age or older to be your Health Care Agent. The only restriction is that you cannot appoint your doctor or any other person who directly provides health care to you.
- Unless you expressly limit the duration of or revoke your Georgia Advance Directive for Health Care, or a court acting in your behalf terminates it, your Health Care Agent may exercise the powers you have given him or her throughout your lifetime, even after you become disabled, incapacitated, or incompetent.
- If you change your mind, your Georgia Advance Directive for Health Care can be easily amended or canceled.

**Note:** This information is a general summary of the rights of competent adults in Georgia. It does not contain all the technical details of the law. Also, it does not deal with decisions for minors or for those who are now mentally incapable, nor does it apply to treatment outside of Georgia. It is not the intent of this document to provide specific legal or medical advice. Individuals are encouraged to consult professionals such as physicians, clergy and lawyers to help them make informed decisions.



# Georgia Advance Directive for Health Care

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

## *Copies of this document have been given to:*

**1:** \_\_\_\_\_

\_\_\_\_\_  
*(Provide complete name, address and phone number)*

**2:** \_\_\_\_\_

\_\_\_\_\_  
*(Provide complete name, address and phone number)*

**3:** \_\_\_\_\_

\_\_\_\_\_  
*(Provide complete name, address and phone number)*

**4:** \_\_\_\_\_

\_\_\_\_\_  
*(Provide complete name, address and phone number)*

**5:** \_\_\_\_\_

\_\_\_\_\_  
*(Provide complete name, address and phone number)*

## ***This advance directive for health care has four parts:***

### ***Part I: Health Care Agent.***

This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a Health Care Agent. You may also have your Health Care Agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your Health Care Agent about this important role.

### ***Part II: Treatment Preferences.***

This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.

### ***Part Three: Guardianship.***

This part allows you to nominate a person to be your guardian should one ever be needed.

### ***Part Four: Effectiveness and Signatures.***

This part requires your signature and the signatures of two witnesses. You must complete PART FOUR if you have filled out any other part of this form.

*You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.*

*You should give a copy of this completed form to people who might need it, such as your Health Care Agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new Georgia Advance Directive for Health Care.*

*Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care may be used in Georgia.*

*You may revoke this completed form at any time. This completed form will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form.*

## Part One: Health Care Agent

PART ONE will be effective even if PART TWO is not completed. A physician or health care provider who is directly involved in your health care may not serve as your Health Care Agent. If you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your Health Care Agent. If you are not married, a future marriage will revoke the selection of your Health Care Agent unless the person you selected as your Health Care Agent is your new spouse.

### 1. Health Care Agent

I select the following person as my Health Care Agent to make health care decisions for me:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_  
(Home, Work, and Mobile)

### 2. Back-Up Health Care Agent

*This section is optional. PART ONE will be effective even if this section is left blank.*

If my Health Care Agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my Health Care Agent is unavailable or unable or unwilling to act as my Health Care Agent, then I select the following, each to act successively in the order named, as my back-up Health Care Agent(s):

*Back-up Health Care Agent #1:*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_  
(Home, Work, and Mobile)

*Back-up Health Care Agent #2:*

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_  
(Home, Work, and Mobile)

### 3. General Powers of Health Care Agent

My Health Care Agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my Health Care Agent communicate my health care decisions.

My Health Care Agent will have the same authority to make any health care decision that I could make. My Health Care Agent's authority includes, for example, the power to:

- Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- Request, consent to, withhold, or withdraw any type of health care; and
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my Health Care Agent will not be financially liable for any services or care contracted for me or on my behalf).

My Health Care Agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My Health Care Agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger. My Health Care Agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My Health Care Agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

**I understand that under Georgia law:**

- My Health Care Agent may refuse to act as my health care agent;
- A court can take away the powers of my Health Care Agent if it finds that my Health Care Agent is not acting properly; and
- My Health Care Agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.

**4. Guidance for Health Care Agent**

When making health care decisions for me, my Health Care Agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my Health Care Agent should make decisions for me that my Health Care Agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

**5. Powers of Health Care Agent After Death**

**A. AUTOPSY**

My Health Care Agent will have the power to authorize an autopsy of my body unless I have limited my Health Care Agent's power by initialing below.

\_\_\_\_\_ My Health Care Agent will not have the power to authorize an autopsy of my body  
(Initials) (unless an autopsy is required by law).

**B. Organ Donation and Donation of Body**

My Health Care Agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless I have limited my Health Care Agent's power by initialing below.

*Initial each statement that you want to apply.*

\_\_\_\_\_ My Health Care Agent will not have the power to make a disposition of my body for use in a  
(Initials) medical study program.

\_\_\_\_\_ My Health Care Agent will not have the power to donate any of my organs.  
(Initials)

### C. Final Disposition of Body

My Health Care Agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

\_\_\_\_\_ I want the following person to make decisions about the final disposition of my body:  
(Initials)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_  
(Home, Work, and Mobile)

I wish for my body to be:

\_\_\_\_\_ Buried OR \_\_\_\_\_ Cremated  
(Initials) (Initials)

### Part Two: Treatment Preferences

PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a Health Care Agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a Health Care Agent in PART ONE, then your Health Care Agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your Health Care Agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.

### 6. Conditions

PART TWO will be effective if I am in any of the following conditions:

*Initial each condition in which you want PART TWO to be effective.*

\_\_\_\_\_ A terminal condition, which means I have an incurable or irreversible condition that will result  
(Initials) in my death in a relatively short period of time.

\_\_\_\_\_ A state of permanent unconsciousness, which means I am in an incurable or irreversible  
(Initials) condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

## 7. Treatment Preferences

State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

A. \_\_\_\_\_  
(Initials) Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

**Or**

B. \_\_\_\_\_  
(Initials) Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

**Or**

C. \_\_\_\_\_  
(Initials) I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:

*Initial each statement that you want to apply to option C.*

\_\_\_\_\_ If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.  
(Initials)

\_\_\_\_\_ If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.  
(Initials)

\_\_\_\_\_ If I need assistance to breathe, I want to have a ventilator used.  
(Initials)

\_\_\_\_\_ If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.  
(Initials)

## 8. Additional Statements

*This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your Health Care Agent (if you have selected a Health Care Agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your Health Care Agent (if you have selected a Health Care Agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.*

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## 9. In Case of Pregnancy

PART TWO *will be effective even if this section is left blank.*

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

\_\_\_\_\_ I want PART TWO to be carried out if my fetus is not viable.  
(Initials)

## Part Three: Guardianship

### 10. Guardianship

PART THREE *is optional. This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a Health Care Agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your Health Care Agent and guardian are not the same person, your Health Care Agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.*

*State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.*

A. \_\_\_\_\_ I nominate the person serving as my Health Care Agent under PART ONE to serve as my guardian.  
(Initials)

**OR**

B. \_\_\_\_\_ I nominate the following person to serve as my guardian:  
(Initials)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Numbers: \_\_\_\_\_  
(Home, Work, and Mobile)

## Part Four: Effectiveness and Signatures

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

\_\_\_\_\_ This advance directive for health care will become effective on or upon \_\_\_\_\_  
(Initials)  
and will terminate on or upon \_\_\_\_\_.

*You must sign and date or acknowledge signing and dating this form in the presence of two witnesses. Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.*

A witness:

- *Cannot be a person who was selected to be your Health Care Agent or back-up Health Care Agent in PART ONE;*
- *Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or*
- *Cannot be a person who is directly involved in your health care.*

*Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).*

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

\_\_\_\_\_  
(Signature of Declarant) (Date)

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

\_\_\_\_\_  
(Signature of First Witness) (Date)

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Second Witness) (Date)

Print Name: \_\_\_\_\_

Address: \_\_\_\_\_

*This form does not need to be notarized.*

## Acceptance by Health Care Agent (Optional)

Your Health Care Agent and back-up Agents are not required by law to act for you nor is it mandatory that they sign this document. However, their signatures provide assurances that they are willing to serve in this capacity.

I accept this appointment to serve as the Health Care Agent for \_\_\_\_\_.  
I understand I must act in accordance with the preferences of the person I represent, as expressed in this Georgia Advance Directive for Health Care or otherwise made known to me. I understand that this document allows me to decide about \_\_\_\_\_'s medical care only while he/she cannot do so or chooses not to do so. I understand that the person who appointed me may revoke this appointment at any time.

I certify that the signature of my agent and back-up agent(s) is correct:

\_\_\_\_\_  
(Signature of Health Care Agent)                      (Date)                      (Signature of Principal)

\_\_\_\_\_  
(Signature Back-up #1)                      (Date)                      (Signature of Principal)

\_\_\_\_\_  
(Signature Back-up #2)                      (Date)                      (Signature of Principal)

## Review (Optional)

It is important that you occasionally review your Georgia Advance Directive for Health Care to make sure this document continues to reflect your treatment preferences. Indicate each time you review the document below.  
If you do not review your Georgia Advance Directive for Health Care it will continue to remain in effect as completed, unless you cancel it.

I have reviewed this Georgia Advance Directive for Health Care and confirm by my signature that this document continues to convey my preferences as of the date specified.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



# What To Do Now

Here are some suggestions to help ensure that your wishes for your final health care are followed:

- Make sure the person you have named as your Health Care Agent and your back-up Agent know what you want. If you have not shared your wishes with these individuals, talk to them the first chance you get.
- Keep your signed original Individual Worksheet and Georgia Advance Directive for Health Care some place where they can be found easily. Do not put them in a safe deposit box which requires a key or combination to open. Tell your Health Care Agent and other loved ones where to find your original documents.
- Give copies of your Individual Worksheet and Georgia Advance Directive for Health Care to your Agent, back-up Agents, and anyone else you think should know what you want (family members, lawyer, spiritual advisor, etc.). Keep a list of the people you give them to in case you change your mind.
- Tell your doctor you have completed a Georgia Advance Directive for Health Care and discuss your decisions with him or her. If you would like, have your doctor put a copy of your Georgia Advance Directive for Health Care in your medical record.
- Use one of the Wallet Cards included in this booklet to indicate that you have completed a Georgia Advance Directive for Health Care and where it can be found. Carry it with you.
- If you are being admitted to a hospital or nursing home, take a copy of your Georgia Advance Directive for Health Care with you. Ask that it be placed in your medical record.
- Plan to review and update your Individual Worksheet and Georgia Advance Directive for Health Care occasionally. As the circumstances of your life change (growing older, being diagnosed with an illness, etc.), your views may change. Marriage, the birth of a child or the death of a loved one may also influence how you feel. Your loved ones will want to know that your Georgia Advance Directive for Health Care is a true expression of your wishes and may have questions about a document that is several years old. Initial and date the forms each time you review them so your loved ones will know you have not changed your mind.
- If you do change your mind, you can cancel your Georgia Advance Directive for Health Care at any time. Be sure to notify everyone who has copies that you are writing a new advance directive, thereby canceling the document they have.
- If you are terminally ill and wish to die at home, you should talk to your doctor, other caregivers, and family members about situations when you might or might not want an ambulance called. If an ambulance is called, the emergency team must give you life-prolonging care until you can get to a hospital and be evaluated by a doctor, unless you have a Do Not Resuscitate/ Allow Natural Death order that is clearly visible in your home or you are wearing an orange arm band or necklace indicating that you have a Do Not Resuscitate/ Allow Natural Death order.

- If you become terminally ill, you can call a hospice in your area and ask for information about the care they can give to you and your family. Many of these programs will work directly with your doctor to arrange for you to have hospice services in addition to your medical care.
- If you are traveling outside of Georgia, it is a good idea to take a copy of your Georgia Advance Directive for Health Care with you. Most states will honor an out-of-state document, but some require that it conform to their own laws. If you are going to receive medical care out of state, ask the medical facility where you will be treated to give you information about their laws and requirements.



EMORY  
CENTER FOR  
ETHICS



CRITICAL Conditions™  
Make your final health care decisions

*We cannot know when we will die. It could happen tomorrow, next year, or perhaps not for decades. By discussing and planning for your final health care, you have helped ease your passage, whenever it comes, for those you love.*

# GADFHC

(Georgia Advance Directive for Health Care)

## Wallet Cards

Four **CRITICAL Conditions<sup>SM</sup>** Wallet Cards are provided for your use. Once filled out, each card will contain all the information necessary for locating your Georgia Advance Directive for Health Care and notifying your Health Care Agent (or back-up). Detach the Wallet Cards. Fill out as many as you feel you need. Carry at least one card with you. Additional cards may be given to family members.

The **CRITICAL Conditions<sup>SM</sup>** Planning Guide was developed by Georgia Health Decisions, a non-profit, non-partisan organization that engages the people of Georgia in dialogue on health care issues.

### **CRITICAL Conditions<sup>SM</sup>** I have made my Final Health Care Decisions

Your Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

My Georgia Advance Directive for Health Care can be found at:

Location: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

My Health Care Agent and Back-up Agent are identified on the reverse side of this card.

### **CRITICAL Conditions<sup>SM</sup>** I have made my Final Health Care Decisions

Your Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

My Georgia Advance Directive for Health Care can be found at:

Location: \_\_\_\_\_

Address: \_\_\_\_\_

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### **CRITICAL Conditions<sup>SM</sup>** I have made my Final Health Care Decisions

Your Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

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My Health Care Agent and Back-up Agent are identified on the reverse side of this card.

### **CRITICAL Conditions<sup>SM</sup>** I have made my Final Health Care Decisions

Your Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

My Georgia Advance Directive for Health Care can be found at:

Location: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

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Agent Name: \_\_\_\_\_  
Agent Address: \_\_\_\_\_  
Agent Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Back-up Agent: \_\_\_\_\_  
Back-up Address: \_\_\_\_\_  
Back-up Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Agent Name: \_\_\_\_\_  
Agent Address: \_\_\_\_\_  
Agent Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Back-up Agent: \_\_\_\_\_  
Back-up Address: \_\_\_\_\_  
Back-up Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Agent Name: \_\_\_\_\_  
Agent Address: \_\_\_\_\_  
Agent Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Back-up Agent: \_\_\_\_\_  
Back-up Address: \_\_\_\_\_  
Back-up Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Agent Name: \_\_\_\_\_  
Agent Address: \_\_\_\_\_  
Agent Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Back-up Agent: \_\_\_\_\_  
Back-up Address: \_\_\_\_\_  
Back-up Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: (H) \_\_\_\_\_ (W) \_\_\_\_\_



*Give your loved ones the information  
they need to act on your behalf*

For more information visit us at:  
<https://www.hcecg.org/CriticalConditionsPlanningGuide>