

# HEALTH CARE ADVANCE DIRECTIVES

YOUR RIGHT TO DECIDE  
AND  
MAKE YOUR WISHES KNOWN



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Every competent adult has the fundamental right of self-determination regarding decisions pertaining to his or her own health, including the right to choose or refuse medical treatment. This right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession.

To ensure that such right is not lost or diminished by virtue of later physical or mental incapacity, the Florida Legislature provided for establishment of a procedure to allow a person to plan for incapacity. The law recognizes the right of a competent adult to make an advance directive instructing his or her physician to provide, withhold, or withdraw life-prolonging procedures, or to designate another to make the treatment decision for him or her in the event that such person should be found incompetent and suffering from a terminal condition.

The Agency for Health Care Administration has prepared a written position summarizing Florida law (Chapter 765, Florida Statutes) regarding health care advance directives. State rules require hospitals, nursing homes, home health agencies and Health Maintenance Organizations (HMOs) to distribute this document or a copy of some other substantially similar document to their patients. The following is the Agency's written position, as referenced in Chapters 59A-3.2055, 59A-4.106, 59A-8.0245, and 59A-12.013, Florida Administrative Code:

### **HEALTH CARE ADVANCE DIRECTIVES THE PATIENT'S RIGHT TO DECIDE**

All adult individuals in health care facilities such as hospitals, nursing homes, hospices, home health agencies, and health maintenance organizations, have certain rights under Florida law.

You have a right to fill out a paper known as an advance directive. The paper says in advance what kind of treatment you want or do not want under special, serious medical conditions — conditions that would stop you from telling your doctor how you want to be treated. For example, if you were taken to a health care facility in a coma, would you want the facility's staff to know your specific wishes about decisions affecting your treatment?

#### **WHAT IS AN ADVANCE DIRECTIVE?**

An advance directive is a written or oral statement which is made and witnessed in advance of serious illness or injury, about how you want medical decisions made. Two forms of advance directives are:

- a Living Will and
- a Health Care Surrogate Designation.

An advance directive allows you to state your choices about health care or to name someone to make those choices for you, if you become unable to make decisions about your medical treatment. An advance directive can enable you to make decisions about your future medical treatment.

#### **WHAT IS A LIVING WILL?**

A living will generally states the kind of medical care you want or do not want if you become unable to make your own decisions. It is called a living will because it takes affect while you are still living. Florida law provides a suggested form for a living will. You may use it or some other form. You may wish to speak to an attorney or physician to be certain you have completed the living will in a way so that your wishes will be understood.

#### **WHAT IS A HEALTH CARE SURROGATE DESIGNATION?**

A health care surrogate designation is a signed, dated and witnessed paper naming another person such as a husband, wife, daughter, son or close friend as your agent to make medical decisions for you, if you should become unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid. Florida law provides a suggested form for designation of a health care surrogate. You may use it or some other form. You may wish to name a second person to stand in for you, if your first choice is not available.

**WHICH IS BETTER?**

You may wish to have both or combine them into a single document that describes treatment choices in a variety of situations and names someone to make decisions for you should you be unable to make decisions for yourself.

**DO I HAVE TO WRITE AN ADVANCE DIRECTIVE UNDER FLORIDA LAW?**

No, there is no legal requirement to complete an advance directive. However, if you have not made an advance directive or designated a health care surrogate, health care decisions may be made for you by a court-appointed guardian, your spouse, your adult child, your parent, your adult sibling, an adult relative, or a close friend in that order. This person would be called a proxy.

**CAN I CHANGE MY MIND AFTER I WRITE A LIVING WILL OR DESIGNATE A HEALTH CARE SURROGATE?**

Yes, you may change or cancel these documents at any time. Any changes should be written, signed and dated. You can also change an advance directive by verbal statement.

**WHAT IF I HAVE FILLED OUT AN ADVANCE DIRECTIVE IN ANOTHER STATE AND NEED TREATMENT IN A HEALTH CARE FACILITY IN FLORIDA?**

An advance directive completed in another state, in compliance with the other state's law, can be honored in Florida.

**WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE IF I CHOOSE TO HAVE ONE?**

Make sure that someone such as your doctor, lawyer or family member knows that you have an advance directive and where it is located. Consider the following:

- If you have designated a health care surrogate, give a copy of the written designation form or the original to the person.
- Give a copy of your advance directive to your doctor for your medical file.
- Keep a copy of your advance directive in a place where it can be found easily.
- Keep a card or note in your purse or wallet which states that you have an advance directive and where it is located.
- If you change your advance directive, make sure your doctor, lawyer and/or family member has the latest copy.

**FOR FURTHER INFORMATION, ASK THOSE IN CHARGE OF YOUR CARE.**

## **ADDITIONAL INFORMATION REGARDING HEALTH CARE ADVANCE DIRECTIVES**

Florida law (Chapter 765, Florida Statutes) addresses the two most common documents through which individuals may make their wishes known: the living will and the health care surrogate designation. Suggested forms for living will declarations and health surrogate designations are also included in the law. Copies of these forms are included in this document. The procedures are simple and do not require an attorney, although you may consult one if you feel more comfortable. The documents may be properly executed with the signature of two witnesses, one of whom is neither a spouse nor a blood relative.

Before making a decision about advance directives, however, you might want to review other sources of information, including the following:

- Prehospital Do Not Resuscitate Order (DNRO) – This document is also allowed by Florida law. The form, issued by the Department of Health, relates to your advance directives should there be an occasion for Emergency Medical Services (EMS) prior to admittance to a hospital.
- A durable power of attorney, which designates someone to act in your behalf for a variety of activities (financial management, etc.), may also include your health care advance directives. You should consult an attorney about preparation of this document.
- There are various forms that satisfy the requirements of Florida law regarding the living will. Many are more detailed than the basic form provided in this document. Some forms, such as the FIVE WISHES produced by the Commission on Aging with Dignity, allow you to specify or complete a checklist of details regarding your wishes. Included are such items as assistance with breathing, food by tubes, fluid intake by needles, surgery that is life-saving but won't improve or cure your condition, and pain medications to keep you comfortable. A number of organizations have forms for advance directives you might want to review. Some of these sources are listed below.

### **PREHOSPITAL DO NOT RESUSCITATE ORDER (DNRO)**

Department of Health  
Bureau of Emergency Medical Services  
2020 Capital Circle SE, Bin C18, Tallahassee, FL 32399-1738  
Contact: Jerri White  
Telephone: (850) 245-4440, Ext. 2742

### **FIVE WISHES LIVING WILL AND HEALTH CARE SURROGATE FORMS**

Commission on Aging with Dignity  
P.O. Box 11180, Tallahassee, FL 32302-1180  
1-888-5-WISHES

### **MAKING YOUR WISHES KNOWN – BASIC INFORMATION WITH DOCUMENTS AND FORMS**

Northwest Florida/Big Bend Health Councils  
(850) 872-4128

### **ADDITIONAL SOURCES FOR INFORMATION AND FORMS:**

Local hospitals, nursing homes, hospices and home health services;  
AARP Membership Communications  
601 E. Street NW, Washington, DC  
1-800-424-3410

## A LIVING WILL

Declaration made this \_\_\_\_ day of \_\_\_\_\_, 20\_\_, I, \_\_\_\_\_, willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that if at any time:

\_\_\_\_\_(initial) I have a terminal condition, or  
or \_\_\_\_\_(initial) and I have an end-stage condition, or  
or \_\_\_\_\_(initial) and I am in a persistent vegetative state,

and if my attending or treating physician and another consulting physician have determined that there is no medical probability of my recovery from such condition(s), I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

If I have executed any organ donation documents that are in effect at the time of implementing the instructions of my Living Will, I further authorize my healthcare providers to delay the withdrawal of life support for a reasonable period of time for the recovery of any organs or tissue that may be appropriate for transplantation.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express informed consent regarding the withholding, withdrawal, or continuation of life-prolonging procedures, I wish to designate as my surrogate to carry out the provision of this declaration:

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Additional instructions: (optional) \_\_\_\_\_

Signed \_\_\_\_\_

*(At least one witness must not be the subject's spouse nor a blood relative of the declarant.)*

Witness \_\_\_\_\_ Witness \_\_\_\_\_

Address \_\_\_\_\_ Address \_\_\_\_\_

Phone \_\_\_\_\_ Phone \_\_\_\_\_

**DESIGNATION OF HEALTH CARE SURROGATE**

Name \_\_\_\_\_  
(LAST NAME) (FIRST NAME) (MIDDLE INITIAL)

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name \_\_\_\_\_

Address \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone \_\_\_\_\_

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray cost of health care; and to authorize my admission to or transfer from a health care facility.

Additional instructions (optional):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I further affirm that this designation is not being made a condition of treatment or admission to a health care facility. I will notify and send a copy of this document to the following persons other than my surrogate, so they may know who my surrogate is.

Name \_\_\_\_\_

Name \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_




Witnesses: 1. \_\_\_\_\_

2. \_\_\_\_\_

*(At least one witness must be neither a spouse nor a blood relative of the signatory.)*

**HEALTH CARE ADVANCE DIRECTIVES  
WALLET CARDS**

The cards below may be used as a convenient method to inform others of your health care advance directives. Complete the cards and cut them out. Place one in your wallet or purse and place the other on your refrigerator, in your motor vehicle glove compartment, or other easy-to-find place.




**Health Care  
Advance Directives**




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FOLD

**Agency for Health Care Administration  
Information Center  
1-888-419-3456**



CUT ON DOTTED LINES  
THEN FOLD




**Health Care  
Advance Directives**

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FOLD

**Agency for Health Care Administration  
Information Center  
1-888-419-3456**



CUT ON DOTTED LINES  
THEN FOLD

  
**Health Care Advance Directives**

I, \_\_\_\_\_  
have created the following Advance Directives(s):

- Living Will
- Health Care Surrogate Designation
- Other (specify) \_\_\_\_\_

**FOLD**

**Contact:**

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

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

\_\_\_\_\_

Telephone: \_\_\_\_\_

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

  
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have created the following Advance Directives(s):

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- Other (specify) \_\_\_\_\_

**FOLD**

**Contact:**

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

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

\_\_\_\_\_

Telephone: \_\_\_\_\_

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

