STATE OF DELAWARE ADVANCE DIRECTIVE

PART I. INSTRUCTIONS FOR HEALTH CARE DECISIONS

If you are an adult who is mentally competent, you have the right to accept or refuse medical or surgical treatment, if such refusal is not contrary to existing public health laws. You may give advance instructions for medical or surgical treatment that you want or do not want. Theses instructions will become effective if you lose the capacity to accept or refuse medical or surgical treatment. You may limit your instructions to take effect only if you are in a specified medical condition. If you give an instruction that you do not want your life prolonged, that instruction will only take effect if you are in a "qualifying condition." A "qualifying condition" is either a terminal condition or permanent unconsciousness.

If you want to give instructions to accept or refuse medical or surgical treatment, you should fill in the spaces below. You may cross out any wording you do not want.

A. END OF LIFE INSTRUCTIONS

1. Choice To Prolong Life

_____I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

OR

2. Choice To Not Prolong Life

_____ I do not want my life to be prolonged if (please check all that apply)

(i) I have a terminal condition (an incurable condition from which there is no reasonable medical expectation of recovery and which will cause my death, regardless of the use of life-sustaining treatment). In this case, I give the specific directions indicated:

Artificial nutrition through a conduit	YES	NO
Hydration through a conduit	YES	NO
Cardiopulmonary resuscitation	YES	NO
Mechanical respiration	YES	NO
Other (explain) _____	YES	NO

_____

_____(ii) I become permanently unconscious (a medical condition that has existed at least four (4) weeks and has been diagnosed in accordance with currently accepted medical standards and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma) and regarding the following, I give the specific directions indicated:

Artificial nutrition through a conduit	YES	NO
Hydration through a conduit	YES	NO
Cardiopulmonary resuscitation	YES	NO
Mechanical respiration	YES	NO
Other (explain) _____	YES	NO

_____

B. RELIEF FROM PAIN: Whether I chose A.1 or A.2, or neither, I direct that in all cases I be given all medically appropriate care necessary to make me comfortable and alleviate pain.

C. OTHER MEDICAL INSTRUCTION: If you wish to add to the instructions you have given above, you may do so here. Use additional sheets, if necessary.

_____

_____

PART II: POWER OF ATTORNEY FOR HEALTH CARE

Your agent may make any health care decisions that you could have made while you had the capacity to make health care decisions. You may appoint an alternate agent to made health care decisions for you. Unless the persons you name as agent and alternate agent are related to you by blood, neither may own, operate or be employed by any residential long-term care institution where you are receiving care.

If you wish to appoint an agent to make health care decisions for you under these circumstances and conditions, you must fill out the section below. You may cross out any wording you do not want.

A. DESIGNATION OF AGENT: I designate _____ as my agent to make health care decisions for me. If he/she is not living, willing or able, or reasonable available, to make health care decisions for me, then I designate _____ _____ as my agent to make health care decisions for me.

_____

(name of individual you choose as agent)

_____

(address) (city) (state) (zip)

_____

(home phone) (work phone)

_____

(name of individual you choose as alternate agent)

_____

(address) (city) (state) (zip)

_____

(home phone) (work phone)

B. AGENT'S AUTHORITY: I grant to my agent full authority to make decisions for me regarding my health care; provided that, in exercising this authority, my agent shall follow my desires as stated in this document or otherwise known to my agent. Accordingly, my agent is authorized as follows:

1. To consent to, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function;
2. To have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;
3. To authorize my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service;
4. To contract for any health care related service or facility on my behalf, without my agent incurring personal financial liability for such contracts;
5. To hire and fire medical, social service, and other support personnel responsible for my care; and
6. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten then moment of (but not intentionally cause) my death.

C. WHEN AGENT'S AUTHORITY BECOME EFFECTIVE: My agent's authority becomes effective when my attending physical determines I lack the capacity to make my own health care decisions.

D. AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 1 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, health care decisions by my agent shall conform as closely as possible to what I would have done or intended under the circumstances. If my agent is unable to determine what I would have done or intended under the circumstances, my agent will make health care decisions for me in accordance with what my agent determines to be my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

PART III. ANATOMICAL GIFT DECLARATION (OPTIONAL)

I hereby make the following anatomical gift(s) to take effect upon my death. The marks in the appropriate parenthesis and words filled into the blanks below indicate my desires:

I give ( ) my body;
( ) any needed organs or parts;
( ) the following organs or parts _____
to ( ) the physician in attendance at my death;
( ) the hospital in which I die;
( ) the following named physician, hospital, storage bank or other medical institution _____

EFFECT OF COPY: A copy of this form has the same effect as the original.
I understand the purpose and effect of this document.

_____ _____
(date) (sign your name)

_____
(print your name)

_____
(address)

_____
(city and state) (zip)

STATEMENT OF WITNESSES
SIGNED AND DECLARED by the above-named declarant as and for his/her written declaration under 16 Del.C. Sections 2502, 2503, in our presence, who in his/her presence, at his/her request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state:
A. The Declarant is mentally competent.
B. That neither of us is prohibited by Section 2503 of Title 16 of the Delaware Code from being a witness. Neither of us:

1. Is related to the declarant by blood, marriage or adoption;
2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the executing of the advance health care directive, is so entitled by operation of law then existing;
3. Has, at the time of the execution of the advance health care directive, a present or inchoate claim against any portion of the estate of the declarant;
4. Has a direct financial responsibility for the declarant's medical care;
5. Has a controlling interest in or is an operation or an employee of a health care institution in which the declarant is a patient or resident; or
6. Is under eighteen years of age.

C. That is the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses, _____ _____, is at the time of the execution of the advance health care directive, a patient advocate or ombudsman designated by the Division of Services for Aging and Adults with Physical Disabilities or the Public Guardian.

Witness	Witness
_____	_____
(print name)	(print name)
_____	_____
(address)	(address)
_____	_____
(city, state, zip code)	(city, state, zip code)
_____	_____
(signature of witness)	(signature of witness)
_____	_____
(date)	(date)

OPTIONAL

Sworn and subscribed to me this _____day of _____.

My term expires: _____ _____

(Notary)