MAINE ADVANCE HEALTH-CARE DIRECTIVE

Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator or employee of a residential long-term health-care institution at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health-care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:
(a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;
(b) Select or discharge health-care providers and institutions;
(c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and
(d) Direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care, including life-sustaining treatment.

Part 2 of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. You must have 2 other individuals sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution

at which you are receiving care and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.
You have the right to revoke this advance health-care directive or replace this form at any time.

PART 1 POWER OF ATTORNEY FOR HEALTH CARE
(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me:

_____
(name of individual you choose as agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

_____
(name of individual you choose as first alternate)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

_____
(name of individual you choose as second alternate)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to make all health-care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health-care decisions unless I mark the following box. If I mark this box [ ], my agent's authority to make health-care decisions for me takes effect immediately.

(4) 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 2 of this form and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able or reasonably available to act as guardian, I nominate the alternate agents whom I have named, in the order designated.

PART 2 INSTRUCTIONS FOR HEALTH CARE

If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health-care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have marked below:

[ ] (a) Choice Not To Prolong Life

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) the likely risks and burdens of treatment would outweigh the expected benefits, OR

[ ] (b) Choice To Prolong Life

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

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I mark the following box. If I mark this box [ ], artificial nutrition and hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

(Add additional sheets if needed)

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

_____

_____

(Add additional sheets if needed)

PART 3 DONATION OF ORGANS AT DEATH (OPTIONAL)

(10) Upon my death (mark applicable box)

[ ] (a) I give any needed organs, tissues or parts, OR
[ ] (b) I give the following organs, tissues or parts only

_____

(c) My gift is for the following purposes (strike any of the following you do not want)
(i) Transplant
(ii) Therapy
(iii) Research
(iv) Education

PART 4 PRIMARY PHYSICIAN (OPTIONAL)

(11) I designate the following physician as my primary physician:

_____

(name of physician)

_____

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

_____

(phone)

OPTIONAL: If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) SIGNATURES: Sign and date the form here:

_____
(date) (sign your name)

_____
(address) (print your name)

_____
(city) (state)

SIGNATURES OF WITNESSES:

First Witness	Second Witness
_____ (print name)	_____ (print name)
_____ (address)	_____ (address)
_____ (city and state)	_____ (city and state)
_____ (signature of witness)	_____ (signature of witness)
_____ (date)	_____ (date)