DELAWARE 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 anatomical gifts 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. 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, an agent may not have a controlling interest in or be an operator or employee of a residential long-term health-care institution at which you are receiving care.

If you do not have a qualifying condition (terminal illness/injury or permanent unconsciousness), your agent may make all health-care decisions for you except for decisions providing, withholding or withdrawing of a life sustaining procedure. Unless you limit the agent's authority, 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 unless it's a life-sustaining procedure or otherwise required by law.

(b) Select or discharge health-care providers and health-care institutions;

If you have a qualifying condition, your agent may make all health-care decisions for you, including, but not limited to:

(c) The decisions listed in (a) and (b).

(d) Consent or refuse consent to life sustaining procedures, such as, but not limited to, cardiopulmonary resuscitation and orders not to resuscitate.

(e) Direct the providing, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

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 instructions for other than end of life decisions.

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. It is required that 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 the person 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 agent)

_____
(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 agent)

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

_____ _____
(home phone) (work phone)

(2) AGENT'S AUTHORITY: If I am not in a qualifying condition my agent is authorized to make all health-care decisions for me, except decisions about life-sustaining procedures and as I state here; and if I am in a qualifying condition, my agent is authorized to make all health-care decisions for me, except as I state here:

_____

_____

_____
(Add additional sheets if necessary.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines I lack the capacity to make my own health-care decisions. As to decisions concerning the providing, withholding and withdrawal of life-sustaining procedures my agent's authority becomes effective when my primary physician

determines I lack the capacity to make my own health-care decisions and my primary physician and another physician determine I am in a terminal condition or permanently unconscious.

(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, (please check one):

[ ] I nominate the agent(s) whom I named in this form in the order designated to act as guardian.

[ ] I nominate the following to be guardian in the order designated:

_____

_____

_____

[ ] I do not nominate anyone to be guardian.

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: If I am in a qualifying condition, 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:

Choice Not To 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 caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life-sustaining procedures, there can be no recovery) and regarding artificial nutrition and hydration,

I make the following specific directions: (circle your selection)

Artificial nutrition through a conduit: I want used I do not want used

Hydration through a conduit: I want used I do not want used

_____ (ii) I become permanently unconscious (a medical condition that has been diagnosed in accordance with currently accepted medical standards that has lasted at least 4 weeks 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 artificial nutrition and hydration,

I make the following specific directions: (circle your selection)

Artificial nutrition through a conduit: I want used I do not want used

Hydration through a conduit: I want used I do not want used

Choice to Prolong Life

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

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

_____

_____

_____

(7) OTHER MEDICAL INSTRUCTIONS: (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 necessary.)

PART 3: ANATOMICAL GIFTS AT DEATH
(OPTIONAL)

(8) I am mentally competent and 18 years or more of age.

I hereby make this anatomical gift to take effect upon my death. The marks in the appropriate squares 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 following person or institutions:

[ ] the physician in attendance at my death;

[ ] the hospital in which I die;

[ ] the following named physician, hospital, storage bank or other medical institution:

_____

[ ] the following individual for treatment:

_____

For the following purposes:

[ ] any purpose authorized by law;

[ ] transplantation;

[ ] therapy;

[ ] research;

[ ] medical education.

PART 4: PRIMARY PHYSICIAN
(OPTIONAL)

(9) 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)

Primary Physician shall mean a physician designated by an individual or the individual's agent or guardian, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility.

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

(11) SIGNATURE: Sign and date the form here:

I understand the purpose and effect of this document.

_____ _____
(sign your name) (print your name)

_____
(date)

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

(12) SIGNATURES OF WITNESSES:

Statement of Witnesses

SIGNED AND DECLARED by the above-named declarant as and for his/her written declaration under 16 Del.C. §§ 2502 and 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. That the Declarant is mentally competent.

B. That neither of them:

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 operator or an employee of a residential long-term health-care institution in which the declarant is a resident; or

6. Is under eighteen years of age.

C. That if 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.

First Witness:	Second Witness:
_____	_____
(print name)	(print name)
_____	_____
(address)	(address)
_____	_____
(city, state, zip code)	(city, state, zip code)
_____	_____
(signature of witness)	(signature of witness)

_____ (date)

I am not prohibited by §2503 of Title 16 of the Delaware Code from being a witness.

_____ (date)

I am not prohibited by § 2503 of Title 16 of the Delaware Code from being a witness.