**ADVANCE CARE PLAN**

I, **{CLIENT\_NAME}**, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

**AGENTS:** I want the following persons to make health care decisions for me:

Name: {PRIMARY\_AGENT\_NAME} Relation: {PRIMARY\_AGENT\_RELATION}

If my said relation is unwilling or unable to perform in such capacity, I want the following person to make health care decisions for me:

Name: {ALTERNATE\_AGENT\_NAME} Relation: {ALTERNATE\_AGENT\_RELATION}

**QUALITY OF LIFE:**

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions:

PERMANENT UNCONSCIOUS CONDITION: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

PERMANENT CONFUSION: I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

DEPENDENT IN ALL ACTIVITIES OF DAILY LIVING: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.

END-STAGE ILLNESSES: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

**TREATMENT:**

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I do not want the following treatment:

CPR (Cardiopulmonary Resuscitation): To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.

Life Support / Other Artificial Support: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.

Treatment Of New Conditions: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.

Tube Feeding/IV Fluids: Use of tubes to deliver food and water to patient’s stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions, such as burial arrangements, hospice care, etc.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Organ donation** (optional): Upon my death, I wish to make the following anatomical gifts (please mark one):

Any organ/tissue  My entire body  Only the following organs/tissues: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This the \_\_\_\_\_\_\_\_\_ day of {EXEC\_MONTH}, {EXEC\_YEAR}.

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

**{CLIENT\_NAME}**

Witnesses:

1. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient’s estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient’s signature on this form.
2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient’s estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient’s signature on this form.

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WITNESS 2

STATE OF TENNESSEE

COUNTY OF MAURY

Personally appeared before me, the undersigned Notary Public of said state and county, {CLIENT\_NAME}, the within named bargainor, with whom I am personally acquainted (or proved to me on the basis of satisfactory evidence), and who acknowledged that {CLIENT\_PRONOUN} executed the within instrument for the purposes therein contained and expressed.

WITNESS my hand and seal at office in Columbia, Tennessee, this the \_\_\_\_\_\_\_\_\_ day of {EXEC\_MONTH}, {EXEC\_YEAR}.

My commission expires: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Notary Public