State of Connecticut

# *CONSOLIDATED HEALTH CARE INSTRUCTIONS AND ADVANCE DIRECTIVES OF*

_____

(Printed Name)

_____

(Address)

To Any Physician Who Is Treating Me, this document contains the following:

**I. Appointment of A Health Care Representative**

**II. Living Will and Health Care Instructions**

**III. Document of Anatomical Gift**

**IV. Designation of A Conservator Of The Person For My Future Incapacity**

As my physician, you may rely on these health care instructions and decisions made by my health care representative or conservator of my person, if I am unable to make a decision for myself.

## I. APPOINTMENT OF A HEALTH CARE REPRESENTATIVE

A. ►_____ By my initials here, I choose NOT to appoint a health care representative. **PLEASE GO TO NEXT SECTION; or**

B. I appoint _____ whose address is _____ to be my health care representative. If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, my health care representative is authorized make any and all health care decisions for me, including the decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition and the decision to provide, withhold or withdraw life support systems, except as otherwise provided by law which excludes for example psychosurgery or shock therapy.

I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

C. If _____ is unwilling or unable to serve as my health care representative, I appoint _____ whose address is _____ to be my alternative health care representative.

D. I further instruct that, as required by law, my attending physician disclose to my health care representative protected health information regarding my ability to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment at the representative's request made at anytime after I sign this form.

## II. LIVING WILL and HEALTH CARE INSTRUCTIONS

A. ►_____ By my initials here, I choose NOT to provide Health Care Instructions, **PLEASE GO TO NEXT SECTION; or**

B. If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a statement of my wishes.

I, _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems.

By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

C Specific Instructions

1. Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated below that I desire a particular treatment to be provided.

a. ►_____ I do not want ANY life support systems of any kind; OR

b. ►_____ I do not want any life support systems EXCEPT the following:

| | **Provide** |
|---|---|
| Cardiopulmonary Resuscitation | _____ |
| Artificial Respiration (including a respirator) | _____ |
| Artificial means of providing nutrition and hydration | _____ |
| Other: _____ | _____ |
| _____ | _____ |

2. Listed below are my instructions regarding other specific health care requests:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

D. I DO want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

## III. DOCUMENT OF ANATOMICAL GIFT

A. ►_____ By my initials here I choose NOT to make an anatomical gift at this time; **PLEASE GO TO NEXT SECTION; or**

B. ►_____ I hereby make this anatomical gift, if medically acceptable, to take effect upon my death.

1. I give: (check one)

_____ (a) any needed organs or parts; or

_____ (b) only the following organs or parts: _____

_____

_____

2. to be donated for: (check one)

_____ (a) any of the purposes stated in subsection (a) of sec. 19a-279f of the general statutes; or

_____ (b) these limited purposes -- _____
_____
_____
_____
_____

## IV. DESIGNATION OF A CONSERVATOR OF THE PERSON FOR MY FUTURE INCAPACITY

A. ►_____ By my initials here I choose NOT to designate a person to be appointed as my conservator. **PLEASE GO TO NEXT SECTION; or**

B. If a conservator of my person should need to be appointed, I designate _____, whose address is _____ be appointed my conservator.

C. If this person is unwilling or unable to serve as my conservator of my person, I designate _____, whose address is _____ be appointed my conservator.

D. No bond shall be required of either of them in any jurisdiction.

## V. CAPACITY TO EXECUTE DOCUMENT - SIGNATURE

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

X_____L.S. Dated _____, 20____

(Signature)

X_____

(Printed Name)

## WITNESSES' STATEMENTS

This document was signed in our presence by _____, the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

X_____
(Witness' Signature)
X_____
(Witness' Name Printed)
X_____
(Number and Street)
X_____
(City, State and Zip Code)

X_____
(Witness' Signature)
X_____
(Witness' Name Printed)
X_____
(Number and Street)
X_____
(City, State and Zip Code)

## (OPTIONAL FORM)

## WITNESSES' AFFIDAVITS

STATE OF CONNECTICUT )
)
) ss: _____
) (Town)
COUNTY OF_____)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointment of a health care representative, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this _____ day of _____, 20____.

X_____
(Witness' Signature)
x_____
(Witness' Name Printed)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

x_____
(Witness' Signature)
x_____
(Witness' Name Printed)
x_____
(Number and Street)
x_____
(City, State and Zip Code)

Subscribed and sworn to before me by _____and _____, the signing witnesses to the foregoing affidavit this _____ day of _____, 20 _____.

_____
Commissioner of the Superior Court or
Notary Public

_____
(Printed Name)
My Commission expires: _____