ADVANCE DIRECTIVES
Sharing your wishes when you can't speak for yourself
ADVANCE DIRECTIVES ARE FOR EVERYONE

An advance directive is a way to tell your loved ones and doctors your wishes if something happens and you can’t speak for yourself.

A directive can include the type and extent of your medical care. It can help your family and care team better understand your values.

ONLY 37% OF AMERICANS HAVE AN ADVANCE DIRECTIVE.

Being prepared can bring you and your loved ones peace of mind. This book will tell you more about advance care planning and how to

START THE CONVERSATION TODAY.
WHAT IS AN ADVANCE DIRECTIVE?
Advance directive forms are a way to write down your wishes before a crisis. These legal documents tell your loved ones and doctors what medical treatments you want and don’t want in case you can’t speak for yourself.

WHO SHOULD HAVE ONE?
Everyone. Each person may face an unexpected medical crisis. Illness or injury can make anyone unable to make decisions or speak for themselves. That makes it much harder for family and loved ones to know what to do.

WHEN SHOULD I FILL OUT MY ADVANCE DIRECTIVE?
Now. It is best to do it while you are able to think clearly and before a crisis ever happens. It is a good idea to review and update your directive every year.
HOW DO I GET STARTED?
Consider your basic beliefs about life and medicine. Talk about your fears with a loved one. Think about what matters most to you in a crisis:

- Having family nearby?
- Being at home?
- Getting spiritual support?

Use the Utah Advance Health Care Directive forms to record your wishes. Your doctor, nurse, or social worker can help answer any questions.

It’s normal to feel nervous about advance care planning.
With the right forms and help from your care team, you can feel good about the decisions you make.

CAN I CHANGE MY MIND?
Yes. You can change or update a directive any time. Your directive only takes effect if you cannot speak for yourself.

DOES HAVING AN ADVANCE DIRECTIVE KEEP ME FROM GETTING THE BEST CARE?
No. Advance directives do not change the quality of care you get, they just tell which treatments you do or don’t want.

I HAVE A DIRECTIVE IN ANOTHER STATE. DOES IT WORK IN UTAH AND OTHER STATES?
Each state has different laws about directives. Talk with your health care team to see if there are any conflicts with Utah’s laws. If you now live in Utah, you should update your directive to the Utah form.
WHAT IS POWER OF ATTORNEY OR A HEALTH CARE AGENT?

You can have another person make health care decisions for you if you are unable to speak for yourself. You can give that person permission—called medical power of attorney—on a form.

The person you choose is called an agent. It can be a friend, family member, or licensed professional. The person should

- Be 18 years old or older
- Be willing and able to speak on your behalf
- Know you and your wishes well
- Advocate for you with your doctors and family
- Be willing to talk with you about sensitive issues
- Be able to make decisions important to you

When choosing a health care agent, think of someone you trust to talk with your doctors if you can’t.

WHO DO I GIVE THE FORMS TO WHEN THEY ARE COMPLETED?

Give a copy to your agent and one to your primary health care team. Keep a copy in a safe place. Share the forms with anyone you feel would be helpful such as your children, grandchildren, cancer care team, attorney, or clergy person.
FILLING OUT YOUR ADVANCE HEALTH CARE DIRECTIVE

By law, you need a witness with you when you fill out your advance directive. This person will sign the forms when you are done. The witness must be a “disinterested adult” which means

- The witness must be over age 18
- The witness cannot be related to you by blood or marriage
- The witness has no right or interest to your estate

Ask your social worker if you need help finding a witness.

When you fill out the forms:

- Write clearly using black ink.
- Write your name and the date on all pages.
- Use your initials instead of check marks.
- Write your birth date on the first page.
- Cross out sections that you have left blank.

After you fill out the forms:

- Give a copy to your agent. You may also give copies to members of your family.
- Keep the original form with your important papers.
- Take a copy to your next doctor’s appointment.
- If you are a patient at Huntsman Cancer Institute, you can also deliver or mail a copy of your form to the address below.

HEALTH INFORMATION
Huntsman Cancer Institute Hospital, Room 2130
1950 Circle of Hope
Salt Lake City, UT 84112
MORE RESOURCES

A social worker can help you with care planning, filling out the forms, and finding a witness.

You can also find resources in Huntsman Cancer Institute’s G. Mitchell Morris Cancer Learning Center:

📍 Visit the sixth floor of the cancer hospital
📞 Call 1-888-424-2100 toll free
✉️ Email cancerinfo@hci.utah.edu

These online resources may also help:

University of Utah Center on Aging
ucoa.utah.edu/directives

U.S. Living Will Registry
uslivingwillregistry.com/formslist.shtm
Part I: Allows you to name another person to make health care decisions for you when you cannot make decisions or speak for yourself.

Part II: Allows you to record your wishes about health care in writing.

Part III: Tells you how to revoke or change this directive.

Part IV: Makes your directive legal.

My Personal Information

Name: ____________________________________________
Street Address: ______________________________________
City, State, Zip Code: ________________________________
Telephone: (______) _____________________ Cell Phone: (______) _____________________
Birth Date: ____________________________

Part I: My Agent (Health Care Power of Attorney)

A. No Agent
If you do not want to name an agent, initial the box below, then go to Part II; do not name an agent in B or C below. No one can force you to name an agent.
I do not want to choose an agent.

B. My Agent
Agent’s Name: ______________________________________
Street Address: ______________________________________
City, State, Zip Code: ________________________________
Home Phone: (______) _____________________ Cell Phone: (______) _____________________
Work Phone: (______) _____________________

C. My Alternate Agent
This person will serve as your agent if your agent, named above, is unable or unwilling to serve.
Alternate Agent’s Name: ______________________________________
Street Address: ______________________________________
City, State, Zip Code: ________________________________
Home Phone: (______) _____________________ Cell Phone: (______) _____________________
Work Phone: (______) _____________________
### D. Agent’s Authority

If I cannot make decisions or speak for myself (in other words, after my physician or another authorized provider finds that I lack health care decision making capacity under Section 75-2a-104 of the Advance Health Care Directive Act), my agent has the power to make any health care decision I could have made such as, but not limited to:

- Consent to, refuse, or withdraw any health care. This may include care to prolong my life such as food and fluids by tube, use of antibiotics, CPR (cardiopulmonary resuscitation), and dialysis, and mental health care, such as convulsive therapy and psychoactive medications. This authority is subject to any limits in paragraph F of Part I or in Part II of this directive.
- Hire and fire health care providers.
- Ask questions and get answers from health care providers.
- Consent to admission or transfer to a health care provider or health care facility, including a mental health facility, subject to any limits in paragraphs E or F of Part I.
- Get copies of my medical records.
- Ask for consultations or second opinions.

My agent cannot force health care against my will, even if a physician has found that I lack health care decision making capacity.

### E. Other Authority

My agent has the powers below only if I initial the “yes” option that precedes the statement. I authorize my agent to:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>___ YES  ___ NO</td>
<td>Get copies of my medical records at any time, even when I can speak for myself.</td>
</tr>
<tr>
<td>___ YES  ___ NO</td>
<td>Admit me to a licensed health care facility, such as a hospital, nursing home, assisted living, or other facility for long-term placement other than convalescent or recuperative care.</td>
</tr>
</tbody>
</table>

### F. Limits/Expansion of Authority

I wish to limit or expand the powers of my health care agent as follows:

_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

### G. Nomination of Guardian

Even though appointing an agent should help you avoid a guardianship, a guardianship may still be necessary. Initial the "YES" option if you want the court to appoint your agent or, if your agent is unable or unwilling to serve, your alternate agent, to serve as your guardian, if a guardianship is ever necessary.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>___ YES  ___ NO</td>
<td>I, being of sound mind and not acting under duress, fraud, or other undue influence, do hereby nominate my agent, or if my agent is unable or unwilling to serve, I hereby nominate my alternate agent, to serve as my guardian in the event that, after the date of this instrument, I become incapacitated.</td>
</tr>
</tbody>
</table>

### H. Consent to Participate in Medical Research

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>___ YES  ___ NO</td>
<td>I authorize my agent to consent to my participation in medical research or clinical trials, even if I may not benefit from the results.</td>
</tr>
</tbody>
</table>

### I. Organ Donation

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>___ YES  ___ NO</td>
<td>If I have not otherwise agreed to organ donation, my agent may consent to the donation of my organs for the purpose of organ transplantation.</td>
</tr>
</tbody>
</table>
Part II: My Health Care Wishes (Living Will)

I want my health care providers to follow the instructions I give them when I am being treated, even if my instructions conflict with these or other advance directives. My health care providers should always provide health care to keep me as comfortable and functional as possible.

Choose only one of the following options, numbered Option 1 through Option 4, by placing your initials before the numbered statement. Do not initial more than one option. If you do not wish to document end-of-life wishes, initial Option 4. You may choose to draw a line through the options that you are not choosing.

| Option 1 | I choose to let my agent decide. I have chosen my agent carefully. I have talked with my agent about my health care wishes. I trust my agent to make the health care decisions for me that I would make under the circumstances. |
| Initial | |
| Additional comments: |

| Option 2 | I choose to prolong life. Regardless of my condition or prognosis, I want my health care team to try to prolong my life as long as possible within the limits of generally accepted health care standards. |
| Initial | |
| Additional comments: |

| Option 3 | I choose not to receive care for the purpose of prolonging life, including food and fluids by tube, antibiotics, CPR, or dialysis being used to prolong my life. I always want comfort care and routine medical care that will keep me as comfortable and functional as possible, even if that care may prolong my life. |
| Initial | |
| If you choose this option, you must also choose either (a) or (b), below |
| Initial | (a) I put no limit on the ability of my health care provider or agent to withhold or withdraw life-sustaining care. |
| Initial | (b) My health care provider should withhold or withdraw life-sustaining care if at least one of the initialed conditions is met: |
| If you selected (a), above, do not choose any options under (b). | I have a progressive illness that will cause death |
| | I am close to death and am unlikely to recover |
| | I cannot communicate and it is unlikely that my condition will improve |
| | I do not recognize my friends or family and it is unlikely that my condition will improve |
| | I am in a persistent vegetative state |
| Additional comments: |

| Option 4 | I do not wish to express preferences about health care wishes in this directive. |
| Initial | |
| Additional comments |

Name: ___________________________________________
Part II: My Health Care Wishes (continued)

Additional instructions about your health care wishes:

________________________________________________________________________________________________________
________________________________________________________________________________________________________
________________________________________________________________________________________________________

If you do not want emergency medical service providers to provide CPR or other life sustaining measures, you must work with a physician or APRN to complete an order that reflects your wishes on a form approved by the Utah Department of Health.

Part III: Revoking or Changing a Directive

I may revoke or change this directive by:

♦ Writing “void” across the form, burning, tearing, or otherwise destroying or defacing this document or directing another person to do the same on my behalf;
♦ Signing a written revocation of the directive, or directing another person to sign a revocation on my behalf;
♦ Stating that I wish to revoke the directive in the presence of a witness who: is 18 years of age or older; will not be appointed as my agent in a substitute directive; will not become a default surrogate if the directive is revoked; and signs and dates a written document confirming my statement; or
♦ Signing a new directive. (If you sign more than one Advance Health Care Directive, the most recent one applies.)

Part IV: Making My Directive Legal

I sign this directive voluntarily. I understand the choices I have made and declare that I am emotionally and mentally competent to make this directive. My signature on this form revokes any living will or power of attorney form naming a health care agent that I have completed in the past.

Date                                                 Signature

City, County, and State of Residence

I have witnessed the signing of this directive, I am 18 years of age or older, and I am not:
1. Related to the declarant by blood or marriage;
2. Entitled to any portion of the declarant's estate according to the laws of intestate succession of any state or jurisdiction or under any will or codicil of the declarant,
3. A beneficiary of a life insurance policy, trust, qualified plan, pay on death account, or transfer or death deed that is held, owned, made, or established by, or on behalf of, the declarant;
4. Entitled to benefit financially upon the death of the declarant;
5. Entitled to a right to, or interest in, real or personal property upon the death of the declarant;
6. Directly financially responsible for the declarant's medical care;
7. A health care provider who is providing care to the declarant or an administrator at a health care facility in which the declarant is receiving care; or
8. The appointed agent or alternate agent.

Signature of Witness                                 Printed Name of Witness

Street Address                                       City                                      State          Zip

If the witness is signing to confirm an oral directive, describe below the circumstances under which the directive was made.

________________________________________________________________________________________________________
________________________________________________________________________________________________________

Name: ______________________________________________                                               Page 4 of 4