~ Connecticut ~

Advance Directive Christian Version

NOTICE TO PERSON MAKING THIS DOCUMENT

You have the right to make decisions about your health care. No health care may be given to you over your objection, and necessary health care may not be stopped or withheld if you object.

Because your health care providers in some cases may not have had the opportunity to establish a long–term relationship with you, they are often unfamiliar with your beliefs and values and the details of your family relationships. This poses a problem if you become physically or mentally unable to make decisions about your health care.

In order to avoid this problem, you may sign this legal document to specify the person whom you want to make health care decisions for you if you are unable to participate in medical treatment decisions and make those decisions personally. That person is known as your health care representative. You should take some time to discuss your thoughts and beliefs about medical treatment with the person or persons whom you have specified. You may state in this document any types of health care that you do or do not desire, and you may limit the authority of your health care representative. If your health representative is unaware of your desires with respect to a particular health care decision, he or she is required to determine what would be in your best interests in making the decision.

This is an important legal document. It gives your health care representative broad powers to make health care decisions for you. It revokes any prior Advance Directive you may have made. If you wish to change your Advance Directive, you may revoke this document at any time by destroying it, by directing another person to destroy it in your presence, by signing a written and dated statement, or by stating that it is revoked in the presence of two witnesses. If you revoke, you should notify your health care representative, your health care provider(s), and any other person(s) to whom you have given a copy. If your health care representative is your spouse and your marriage is annulled or you are divorced after signing this document, the document is invalid.

Do not sign this document unless you clearly understand it. It is suggested that you keep the original of this document with your personal papers where it can be easily accessed by your health care representative, close family, or friends, if needed.

STATE OF CONNECTICUT
ADVANCE DIRECTIVE

Written in accordance with Connecticut § 19a-575a

THESE ARE MY HEALTH CARE INSTRUCTIONS. MY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE, THE DESIGNATION OF MY CONSERVATOR OF THE PERSON FOR MY FUTURE INCAPACITY, AND MY DOCUMENT OF ANATOMICAL GIFT.

To any physician who is treating me: These are my health care instructions including those concerning the withholding or withdrawal of life support systems, together with the appointment of my health care representative, the designation of my conservator of the person for future incapacity and my document of anatomical gift. As my physician, you may rely on any decision made by my health care representative or conservator of my person, if I am unable to make a decision for myself.

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. The life support systems which I DO NOT want included but are not limited to **(Cross out and initial life support systems you DO want administered.)**:

1. Artificial respiration
2. Cardiopulmonary resuscitation
3. Artificial means of providing nutrition and hydration

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.

DESIGNATION OF PRIMARY AND ALTERNATE HEALTH CARE REPRESENTATIVES

I appoint ________________________________, ____,
Name Address
(______) ___________________, to be my health care representative. If my attending physician determines that I am
Phone
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 to:

1. Convey to my physician my wishes concerning the withholding or removal of life support systems;
2. Take whatever actions are necessary to ensure that any wishes are given effect;
3. Consent, refuse, or withdraw consent to any medical treatment as long as such action is consistent with my wishes concerning the withholding or removal of life support systems; and
4. Consent to any medical treatment designed solely for the purpose of maintaining physical comfort.

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If ________________________________ is unwilling or unable to serve as my health care representative, I appoint ____,
Name

____, (____) ______________________, to be my
Address Phone

alternate health care representative. Neither my primary or alternate health care representative whom I have designated, is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient, or a spouse of any of those persons, unless he or she is also my relative.

NOMINATION OF CONSERVATOR OF PERSON

If a conservator of my person should need to be appointed, I designate __________________________ be appointed my conservator. If __________________________ is unwilling or unable to serve as my conservator, I designate __________________________. No bond shall be required of either of them in any jurisdiction.

ANATOMICAL GIFT

If any of the statements below reflects your desire, place a checkmark on the line next to that statement. You do not have to check any of the statements.

_______ I do not want to make an organ or tissue donation and I do not want my representative or family to do so.

_______ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

____

I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. I give (check one):

_______ any needed organs or parts

_______ only the following organs or parts: ______________________________________

____

____

to be donated for (check one):

_______ any of the purposes stated in subsection (a) of section 19a-279f of the general statutes

_______ these limited purposes: ____

____

____

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The author and witnesses must sign the document at the same time.

STATEMENT OF AUTHOR

(Person creating this Advance Directive)

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 on it unless such party has received actual notice of my revocation of it.

Signature: ____ Date: ______/_____/_____

STATEMENT OF WITNESSES

This document was signed in our presence, by ______________________________, the author of the 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 the 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.

Witness #1

Signature: ___________________________________ Print Name: ________________________

Address: ____

Witness #2

Signature: ___________________________________ Print Name: ________________________

Address: ____

OPTIONAL FORM: WITNESSES' AFFIDAVIT

STATE OF CONNECTICUT

COUNTY OF ______________________

SS. ____________________

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointments 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 ___________________, _____.

Month Year

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Signature of Witness: ___________________________________

Signature of Witness: ___________________________________

Subscribed and sworn to before me this __________ day of ____________________, ______.
Month Year

Notary's Signature: _____________________________________

Commissioner of the Superior Court
Notary Public

My commission expires: ______________

(Print or type name of all persons signing under all signatures)

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ADDENDUM TO THE STATE OF CONNECTICUT ADVANCE DIRECTIVE

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief in the inherent value of human life and that life is a gift from God. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life, and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my health care representative to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My health care representative has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my health care representative to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My health care representative may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death will occur within hours or a few days, my health care representative may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

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3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my health care representative may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my health care representative may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care representative, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care representative and believe that he or she understands any philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care representative under this document.

If I am unable, due to my incapacity, to participate in making a health care decision, my health care representative is instructed to make the health care decision for me, but my health care representative should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care representative shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care representative shall base his or her health care decision on what he or she believes to be in my best interest.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care representative may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, or a treatment facility. My health care representative may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

ADMISSION TO NURSING HOMES

My health care representative may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care representative may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care representative may not so admit me:

A nursing home **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my health care representative may only admit me for short–term stays for recuperative care or respite care.

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PROVISION OF FEEDING TUBE

If I have checked "Yes" to the following, my health care representative may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care representative may not have a feeding tube withheld or withdrawn from me.

My health care representative may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my health care representative may not have a feeding tube withheld or withdrawn from me.

NUTRITION AND HYDRATION

Food and Fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I have checked "Yes" to the "Withhold or withdraw a feeding tube" option in the "PROVISION OF FEEDING TUBE" section of the Advance Directive Document, then a feeding tube may only be withheld or withdrawn from me if:
   a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
   b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my health care representative may make health care decisions for me even if my health care representative knows I am pregnant. If I have checked "No" to the following, my health care representative may not make health care decisions for me if my attorney-in-fact knows I am pregnant.

Health care decision if I am pregnant **Yes ❑** **No ❑**

If I have not checked either "Yes" or "No" immediately above, my health care representative may not make health care decisions for me if he or she knows I am pregnant.

In no event is my health care representative authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

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PREGNANT WOMEN

If I am pregnant, the following applies:

1. My health care representative is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

In exercising authority under this document, my health care representative shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions, or limitations that I wish to state (add more items as appropriate):

1. I request that this Addendum (pages 6-13) be included as a valid part of this Advance Directive document.

2. I request, but not as a requirement, that my health care representative consult my clergy regarding health care decisions.

3. ____

____

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[Attached additional pages, if needed]

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INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care representative has the authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

HIPAA RELEASE STATEMENT

I intend for my health care representative to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my representative the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

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The author and witnesses must sign the document at the same time.

STATEMENT OF AUTHOR

(Person creating this Advance Directive)

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 on it unless such party has received actual notice of my revocation of it.

Signature: ____ Date: _______/_____/_____

STATEMENT OF WITNESSES

This document was signed in our presence, by ______________________________, the author of the 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 the 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.

Witness #1

Signature: ___________________________________ Print Name: ___________________________

Address: ____

Witness #2

Signature: ___________________________________ Print Name: ___________________________

Address: ____

OPTIONAL FORM: WITNESSES' AFFIDAVIT

STATE OF CONNECTICUT

COUNTY OF ___________________________

SS. ________________________

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointments 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 ____________________, ____________.

Month Year

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Signature of Witness: ____

Signature of Witness: ____

Subscribed and sworn to before me this _____ day of ______________________, _____________.
Month Year

Notary's Signature: ____

Commissioner of the Superior Court
Notary Public

My commission expires: ___________________

(Print or type name of all persons signing under all signatures)

STATEMENT OF PRIMARY AND ALTERNATE HEALTH CARE REPRESENTATIVE

I understand that ____ has designated me to be his or her health care
Name of author
representative or alternate health care representative if he or she is ever found to have incapacity and unable to participate in making health care decisions himself or herself. This designation shall not become effective unless the principal is unable to participate in medical treatment decisions.

____ has discussed his or her desires regarding health care decisions with me.
Name of author

Primary's signature: ____

Address: ____

Alternate's signature: ____

Address: ____

CLERGY
Optional

The author has requested that the health care representative consult me, as the author's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the health care representative to help meet the directives as described in this Advance Directive and attached Addendum.

Clergy's signature: ____ Phone: (______) ___________________

Church address: ____

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I have given copies of this Advance Directive – Christian Version to:

____

____

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____

____

____

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