# Ohio Advance Health Care Directive

**This form lets you have a say about how you want to be cared for if you cannot speak for yourself.**

## This form has 3 parts:

### Part 1 Choose a medical decision maker, Page 3

A medical decision maker is a person who can make health care decisions for you if you are not able to make them yourself.

This person will be your advocate.

They are also called a health care agent, attorney in fact, or surrogate.

### Part 2 Make your own health care choices, Page 7

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

### Part 3 Sign the form, Page 13

The form must be signed before it can be used.

**You can fill out Part 1, Part 2, or both.**

**Fill out only the parts you want. Always sign the form in Part 3.**

**2 witnesses need to sign on Page 14, or a notary on Page 15.**

Your Name

Developed by PREPARE™ for your care

www.prepareforyourcare.org

**This is a legal form that lets you have a voice in your health care.**

It will let your family, friends, and medical providers know how you want to be cared for if you cannot speak for yourself.

## What should I do with this form?

- Please share this form with your family, friends, and medical providers.
- Please make sure copies of this form are placed in your medical record at all the places you get care.

## What if I have questions about the form?

- It is OK to skip any part of this form if you have questions or do not want to answer.
- Ask your doctors, nurses, social workers, family, or friends to help.
- Lawyers can help too. This form does not give legal advice.

## What if I want to make health care choices that are not on this form?

- On Page 12, you can write down anything else that is important to you.

## When should I fill out this form again?

- If you change your mind about your health care choices
- If your health changes
- If your medical decision maker changes

Give the new form to your medical decision maker and medical providers.

Destroy old forms.

**We made sure this legal form is easy to read. But, Ohio law requires us to use legal terms and words too. Those legal terms are at the end of this form. Ohio law requires that you read them before signing this form.**

**Share this form and your choices with your family, friends, and medical providers.**

# Part 1 Choose your medical decision maker

## Your medical decision maker can make health care decisions for you if you are not able to make them yourself.

### A good medical decision maker is a family member or friend who:

- is 18 years of age or older
- can talk to you about your wishes
- can be there for you when you need them
- you trust to follow your wishes and do what is best for you
- you trust to know your medical information
- is not afraid to ask doctors questions and speak up about your wishes

Unless they are a family member, or part of your religious order; legally, your decision maker cannot be:

- your doctor
- someone who works at your hospital, clinic, or place where you live or get care
- someone who is in charge of your nursing home (nursing home administrator)

### What will happen if I do not choose a medical decision maker?

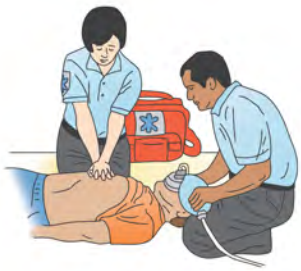
If you are not able to make your own decisions, your doctors may turn to family and friends or a judge to make decisions for you. This person may not know what you want.

## If you are not able, your medical decision maker can choose these things for you:

- doctors, nurses, social workers, caregivers
- hospitals, clinics, nursing homes
- medications, tests, or treatments
- who can look at your medical information

## Here are more decisions your medical decision maker can make:

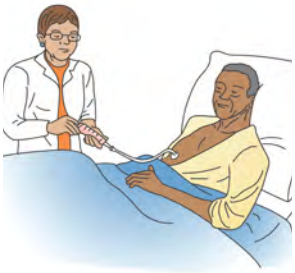
### Start or stop life support or medical treatments, such as:



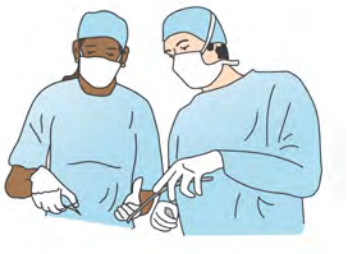
- **CPR or cardiopulmonary resuscitation**
  cardio = heart • pulmonary = lungs • resuscitation = try to bring back

  **This may involve:**
  - pressing hard on your chest to try to keep your blood pumping
  - electrical shocks to try to jump start your heart
  - medicines in your veins

- **Breathing machine or ventilator**
  The machine pumps air into your lungs and tries to breathe for you. You are not able to talk when you are on the machine.
- **Dialysis**
  A machine that tries to clean your blood if your kidneys stop working.
- **Feeding Tube**
  A tube used to try to feed you if you cannot swallow. The tube can be placed through your nose down into your throat and stomach. It can also be placed by surgery into your stomach.



- **Blood and water transfusions (IV)**
  To put blood and water into your body.
- **Surgery**
- **Medicines**



**You may be asked about your wishes if you were in these states:**

- **Permanently unconscious state:** means being in a coma (not aware and not able to feel pain) that doctors decide will not get better.
- **Terminal condition:** means a disease with no cure and death will occur soon without life-support.

## End of life decisions your medical decision maker can make:

- call in a religious or spiritual leader
- decide if you die at home or in the hospital
- decide about autopsy or organ donation

Your Name

## By signing this form, you allow your medical decision maker to:

- agree to, refuse, or withdraw any life support or medical treatment if you are not able to speak for yourself

If there are decisions you do not want them to make, write them here:

## Write the name of your medical decision maker.

**#1: I want this person to make my medical decisions if I am not able to make my own:**

first name _____ last name _____

phone #1 _____ phone #2 _____ relationship _____

address _____ city _____ state _____ zip code _____

**#2: If the first person cannot do it, then I want this person to make my medical decisions:**

first name _____ last name _____

phone #1 _____ phone #2 _____ relationship _____

address _____ city _____ state _____ zip code _____

Your Name _____

## Why did you choose your medical decision maker?

**If you want, you can write why you chose your #1 and #2 decision makers.**

**Write down anyone you would NOT want to help make medical decisions for you.**

## How strictly do you want your medical decision maker to follow your wishes if you are not able to speak for yourself?

Flexibility allows your decision maker to change your prior decisions if doctors think something else is better for you at that time.

Prior decisions may be wishes you wrote down or talked about with your medical decision maker. You can write your wishes in Part 2 of this form.

**Check the one choice you most agree with.**

- ☐ **Total Flexibility:** It is OK for my decision maker to change any of my medical decisions if my doctors think it is best for me at that time.
- ☐ **Some Flexibility:** It is OK for my decision maker to change some of my decisions if the doctors think it is best. But, these wishes I NEVER want changed:

- ☐ **No Flexibility:** I want my decision maker to follow my medical wishes exactly. It is NOT OK to change my decisions, even if the doctors recommend it.

**If you want, you can write why you feel this way.**

**To make your own health care choices, go to Part 2 on Page 7. If you are done, you must sign this form on Page 13.**

**Please share your wishes with your family, friends, and medical providers.**

# Part 2 Make your own health care choices

Fill out only the questions you want.

## How do you prefer to make medical decisions?

Some people prefer to make their own medical decisions. Some people prefer input from others (family, friends, and medical providers) before they make a decision. And, some people prefer other people make decisions for them.

**Please note:** Medical providers cannot make decisions for you. They can only give information to help with decision making.

**How do you prefer to make medical decisions?**

- ☐ I prefer to make medical decisions on my own without input from others.
- ☐ I prefer to make medical decisions only after input from others.
- ☐ I prefer to have other people make medical decisions for me.

**If you want, you can write why you feel this way, and who you want input from.**

## What matters most in life? Quality of life differs for each person.

**What is most important in your life?** Check as many as you want.

- ☐ Your family or friends _____
- ☐ Your pets _____
- ☐ Hobbies, such as gardening, hiking, and cooking
  Your hobbies _____
- ☐ Working or volunteering _____
- ☐ Caring for yourself and being independent
- ☐ Not being a burden on your family
- ☐ Religion or spirituality: Your religion _____
- ☐ Something else _____

**What brings your life joy? What are you most looking forward to in life?**

Your Name

## What matters most for your medical care? This differs for each person.

For some people, the main goal is to be kept alive as long as possible even if:

- They have to be kept alive on machines and are suffering
- They are too sick to talk to their family and friends

For other people, the main goal is to focus on quality of life and being comfortable.

- These people would prefer a natural death, and not be kept alive on machines

Other people are somewhere in between. **What is important to you?**

Your goals may differ today in your current health than at the end of life.

### TODAY, IN YOUR CURRENT HEALTH

**Check one choice along this line to show how you feel today, in your current health.**

| My main goal is to live as long as possible, no matter what. | Equally important | My main goal is to focus on quality of life and being comfortable. |
|---|---|---|

**If you want, you can write why you feel this way.**

### AT THE END OF LIFE

**Check one choice along this line to show how you would feel if you were so sick that you may die soon.**

| My main goal is to live as long as possible, no matter what. | Equally important | My main goal is to focus on quality of life and being comfortable. |
|---|---|---|

**If you want, you can write why you feel this way.**

Your Name

# Quality of life differs for each person at the end of life. What would be most important to you?

## AT THE END OF LIFE

**Some people are willing to live through a lot for a chance of living longer.**

**Other people know that certain things would be very hard on their quality of life.**

- Those things may make them want to focus on comfort rather than trying to live as long as possible.

**At the end of life, which of these things would be very hard on your quality of life?**
Check as many as you want.

- ☐ Being in a coma and not able to wake up or talk to my family and friends
- ☐ Not being able to live without being hooked up to machines
- ☐ Not being able to think for myself, such as severe dementia
- ☐ Not being able to feed, bathe, or take care of myself
- ☐ Not being able to live on my own, such as in a nursing home
- ☐ Having constant, severe pain or discomfort
- ☐ Something else _____

- ☐ **OR**, I am willing to live through all of these things for a chance of living longer.

**If you want, you can write why you feel this way.**

**What experiences have you had with serious illness or with someone close to you who was very sick or dying?**

- If you want, you can write down what went well or did not go well, and why.

**If you were dying, where would you want to be?**

☐ at home ☐ in the hospital ☐ either ☐ I am not sure

**What else would be important, such as food, music, pets, or people you want around you?**

Your Name

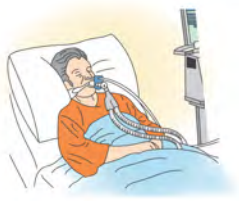
## How do you balance quality of life with medical care?

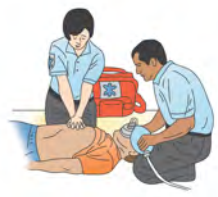
**Sometimes illness and the treatments used to try to help people live longer can cause pain, side effects, and the inability to care for yourself.**

**Please read this whole page before making a choice.**

**AT THE END OF LIFE, some people are willing to live through a lot for a chance of living longer. Other people know that certain things would be very hard on their quality of life.**

Life support treatment can be CPR, a breathing machine, feeding tubes, dialysis, or transfusions.





**Check the one choice you most agree with.**

**If you were so sick that you may die soon, what would you prefer?**

- ☐ **Try all life support treatments** that my doctors think might help. I want to **stay on life support** treatments even if there is little hope of getting better or living a life I value.

- ☐ Do a **trial of life support treatments** that my doctors think might help. But, I **DO NOT want to stay on life support** treatments if the treatments do not work and there is little hope of getting better or living a life I value.

- ☐ **I do not want life support treatments**, and I want to focus on being comfortable. I prefer to have a **natural death**.

**What else should your medical providers and decision maker know about this choice? Or, why did you choose this option?**

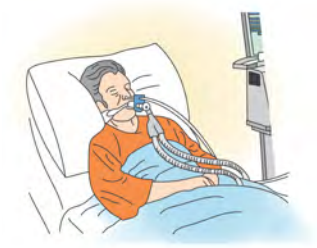
Your Name

## Artificial food and water:

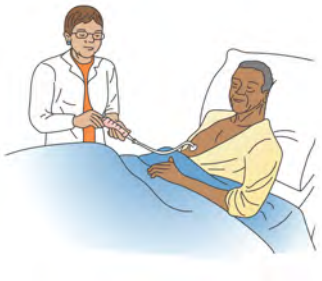
**Initial as many as you want.**

If I am permanently unconscious (a coma that doctors decide will not get better) or have a terminal condition (a disease with no cure and I will die soon without life-support):

Initial here ____ to say it is OK for my medical decision maker and doctors **to stop or say no to food and water by feeding tubes and transfusions (IV).**



Initial here ____ to say it is OK for my medical decision maker and doctors **to stop or say no to other life support treatments**, such as CPR, breathing machines, or dialysis.



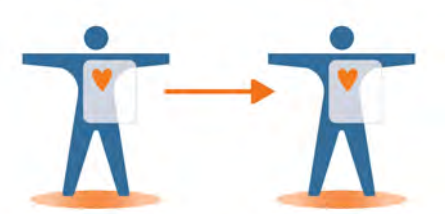
**What else should your medical providers and decision maker know about this choice? Or, why did you choose this option?**

Your Name

# Your decision maker may be asked about organ donation and autopsy after you die. Please tell us your wishes.

## ORGAN DONATION

**Some people decide to donate their organs or body parts.**
**What do you prefer?**



- ☐ I **want** to donate my organs or body parts.

  Which organ or body part do you want to donate?

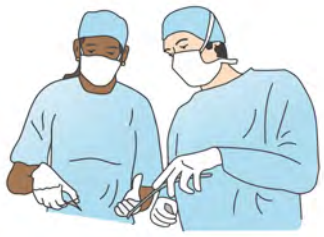
  - ☐ Any organ or body part
  - ☐ Only _____

- ☐ I **do not** want to donate my organs or body parts.

What else should your medical providers and medical decision maker know about donating your organs or body parts?

## AUTOPSY

**An autopsy can be done after death to find out why someone died.**
**It is done by surgery. It can take a few days.**



- ☐ I **want** an autopsy.
- ☐ I **do not** want an autopsy.
- ☐ I **only** want an autopsy if there are questions about my death.

## RELIGIOUS OR SPIRITUAL WISHES

**If you want, you can write down any religious or spiritual wishes.**

Your Name

## What else should your medical providers and medical decision maker know about you and your choices for medical care?

## OPTIONAL: How do you prefer to get medical information?

Some people may want to know all of their medical information. Other people may not.

**If you had a serious illness, would you want your doctors and medical providers to tell you how sick you are or how long you may have to live?**

- ☐ Yes, I would want to know this information.
- ☐ No, I would not want to know. Please talk with my decision maker instead.

**If you want, you can write why you feel this way.**

* Talk to your medical providers so they know how you want to get information.

Your Name

# Part 3 Sign the form

## Before this form can be used, you must:

- sign this form if you are 18 years of age or older
- have two witnesses or a notary who can watch you sign this form

### Sign your name and write the date.

sign your name _____ today's date _____

print your first name _____ print your last name _____ date of birth _____

address _____ city _____ state _____ zip code _____

## Witnesses or Notary

**Before this form can be used, you must have 2 witnesses or a notary sign the form. The job of a notary is to make sure it is you signing the form.**

**Your witnesses must:**

- be 18 years of age or older
- see you sign the form

**Your witnesses cannot:**

- be your medical decision maker
- be your doctor
- be in charge of your nursing home (nursing home administrator)
- be related to you in any way

**Witnesses need to sign their names on Page 14.**
**If you do not have witnesses, a notary must sign on Page 15.**

## Have your witnesses sign their names and write the date.

By signing, I promise that _____ signed this form while I watched.
(the person named on Page 13)

They were thinking clearly and were not forced to sign it.

I also promise that:

- I am 18 years of age or older
- I am not their medical decision maker
- I am not their doctor
- I am not their nursing home administrator
- I am not related to them by blood, marriage, or adoption

### Witness #1

_____ _____
sign your name date

_____ _____
print your first name print your last name

_____ _____ _____ _____
address city state zip code

### Witness #2

_____ _____
sign your name date

_____ _____
print your first name print your last name

_____ _____ _____ _____
address city state zip code

## You are now done with this form.

**Share this form with your family, friends, and medical providers. Talk with them about your medical wishes. To learn more go to www.prepareforyourcare.org**

Developed by PREPARE™ for your care

**Notary Public: Take this form to a notary public ONLY if two witnesses have not signed this form. Bring photo ID (driver's license, passport, etc.).**

**State of Ohio**

County of _____

The foregoing instrument was acknowledged before me this _____ (date)
by _____ (name of person acknowledged.)

_____
Signature of person taking acknowledgment

(Title or rank): _____

(Serial number, if any): _____

## Ohio legal terms we must give you:

We made sure this legal form is easy to read.

But, Ohio law requires us to use legal terms and words too.

The next 3 pages have the legal language we must give you.

**Here are the 4 main points:**

1. You can write down what you prefer on this form.
2. Your medical decision maker must do their best to follow your wishes.
3. If you are in a permanently unconscious state or have a terminal illness: For your medical decision maker to be able to stop or say no to food and water by feeding tubes and transfusions (IV) or life support, you must initial those choices on page 10a.
4. If you are pregnant, the state of Ohio limits the kinds of decisions your medical decision maker can make for you.

**Notice to Adult Executing This Document**

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (your medical decision maker, also known as an attorney in fact) the power to make **most*** health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact **generally*** will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you **generally*** will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

**However***, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact **never*** will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:

(a) You are suffering from an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the attorney in fact is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). (**You should understand that comfort care is defined in Ohio law to mean artificially or technologically administered sustenance (nutrition) or fluids (hydration) when administered to diminish your pain or discomfort, not to postpone your death, and any other medical or nursing procedure, treatment, intervention, or other measure that would be taken to diminish your pain or discomfort, not to postpone your death. Consequently, if your attending physician were to determine that a previously described medical or nursing procedure, treatment, intervention, or other measure will not or no longer will serve to provide comfort to you or alleviate your pain, then, subject to (4) below, your attorney in fact would be authorized to refuse or withdraw informed consent to the procedure, treatment, intervention, or other measure.***);

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) **Refuse or withdraw informed consent to the provision of artificially or technologically administered sustenance (nutrition) or fluids (hydration) to you, unless:**

**(a) You are in a terminal condition or in a permanently unconscious state.**
**(b) Your attending physician and at least one other physician who has examined you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain.**
**(c) If, but only if, you are in a permanently unconscious state, you authorize the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you by doing both of the following in this document:**
**(i) Including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state and if the determination that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain is made, or checking or otherwise marking a box or line (if any) that is adjacent to a similar statement on this document;**
**(ii) Placing your initials or signature underneath or adjacent to the statement, check, or other mark previously described.**
**(d) Your attending physician determines, in good faith, that you authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state by complying with the requirements of (4)(c)(i) and (ii) above.**

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use;

(6) Provide, refuse, or withdraw informed consent to life-sustaining treatment, or the provision of artificially or technologically administered sustenance (nutrition) or fluids ( hydration) to you, if the attorney in fact is subject to a temporary protection order, civil protection order, or any other protection order in this state or another state in which you are the alleged victim.

Additionally, when exercising authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to the attorney in fact in another manner.

When acting pursuant to this document, the attorney in fact **generally*** will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Generally, you may designate any competent adult as the attorney in fact under this document. However, you **cannot*** designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you **cannot*** designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care generally will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicate it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.