



GRIFFIN HEALTH

ADVANCE CARE PLANNING

The Most Important Step: Choose Your Health Care Representative

We don't like to think about it, but life can change in an instant. That's why it's important for EVERY adult to designate a Health Care Representative who will make medical decisions in the event you cannot make them yourself - even if it's temporary.

Completing this one-page advance directive (called an Appointment of Health Care Representative) can be simple:

First - Decide who you trust to be your decision-maker; it's also wise to choose an alternate. Be sure the person you choose:

- is willing and able to assume this role;
- will talk with you about your values, goals and preferences;
- agrees to make decisions you want - even if they would make different decisions; and
- can make medical decisions in difficult circumstances.

Second - Complete the attached document.

- Print your name and date of birth.
- Print the name and phone number of your first-choice Health Care Representative.
- Print the name and phone number of your second-choice Health Care Representative (if selected).
- **STOP!** Do not sign this document until you are in the presence of two (2) witnesses who are NOT your choices for Health Care Representative or the physician who is treating you.
- When your witnesses are present, sign your document. Then print your name as the author of the document, and have both witnesses sign, along with their address and phone number (**Connecticut does not require notarization**).

Third - Make copies and provide one to your:

- Health Care Representative(s)
- Hospital
- Doctors
- Your family members and loved ones, so that everyone knows your wishes

It's that simple - and that important!

For your convenience, we can provide witnesses, make copies for you, and ensure a copy gets into your medical record at Griffin Hospital and your doctor's office. **Just call 203-732-1255.**

Appointment of My Health Care Representative

I (print), _____, born (date of birth) _____, understand that, as a capable adult, I have the right to make decisions about my health care. If there is a time, due to incapacity, that I am unable to make informed consent regarding health care decisions, I instruct those caring for me to seek direction from the **Health Care Representative** I appoint in this document. This person knows my values, preferences and health care wishes, and has legal authority to make any and all health care decisions on my behalf if I am unable to do so myself.

I appoint:

Print name _____
Phone

If my attending physician and another physician both determine that I am unable to understand and appreciate the nature and consequences of health care decisions, and lack the capacity to make and communicate informed decisions regarding my health, **my Health Care Representative is authorized to (1) accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, and (2) make the decision to provide, withhold or withdraw life support systems.**

I direct my Health Care Representative to make decisions on my behalf in accordance with my wishes as stated in a living will, 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 decisions in my best interests, based upon what is known of my wishes and preferences. **Nothing is to be done or omitted with the intention of taking my life.**

If this person is unwilling or unable to serve as my Health Care Representative, or is divorced or legally separated from me, or has died, I appoint the following individuals as alternates:

First alternate (print name) _____
Phone

Second alternate (print name) _____
Phone

This appointment is made, after careful consideration, while I am of sound mind.

x _____
Signature _____
Date

Witnesses' Statement

This document was signed in our presence by _____, the author of this document, who appears to be eighteen years of age or older; is of sound mind; is able to understand the nature and consequences of health care decisions at the time this document is being signed; and is under no duress, fraud or improper influence. We have witnessed this document together in the author's presence and at the author's request.

x _____ Witness' signature	x _____ Witness' signature
_____ Address (Number/Street)	_____ Address (Number/Street)
_____ City/State	_____ City/State
_____ Phone	_____ Phone