Honoring Choices® FLORIDA

Discuss. Decide. Document.

Choose peace of mind and take time to plan ahead now so future health care challenges don't create so many difficult questions and unnecessary worry. Peace of mind comes when you have a conversation about your goals, beliefs and experiences and make your wishes known.

Advance care planning document and instructions are enclosed for:

(Please print your full name) _____

To request additional copies of this booklet for loved ones, or to inquire regarding the availability of a facilitator, call **904.407.7024** or visit **HonoringChoicesFL.com.**

ADVANCE CARE PLANNING

Planning ahead for your future health care needs is one of the most caring things you can do for yourself and your loved ones. If you are in a situation in which you cannot communicate, health care decisions will need to be made. If you have not talked with those closest to you about your wishes, they will have to guess, and that may cause stress and conflict. Your family and health providers cannot honor your wishes unless they know what you want. Tell your family members and health providers the kind of care you would want before a serious illness or injury. Discuss options. Make, communicate and document decisions.

What is advance care planning?

Advance care planning (ACP) is a process of thinking about, discussing, communicating and documenting future medical choices should you experience a sudden illness or injury or a chronic or life-limiting illness. It's more than just the document you complete. Think of it as the end result of an important process that contains your wishes: your advance care plan. Some things you can do as part of advance care planning include:

- Learn more about your health care treatment options.
- Clarify your health care goals.
- Weigh your options about what kind of care and treatment you want or don't want.
- Decide who you want to appoint to speak on your behalf if you are unable to make your own decisions.
- Complete an advance care planning document, putting your wishes in writing.
- Communicate your wishes and share your document with family, friends, clergy, other advisers, physicians and other health care professionals.

What is Honoring Choices Florida?

Honoring Choices Florida is a comprehensive, community-based advance care planning program available at no cost to individuals aged 18 and older. The goal of the program is to work together as a community to change the standard of care people receive by helping them choose the care they want, putting their wishes in writing and ensuring that others follow their wishes. We believe it is important to normalize the ACP conversation. Community Hospice & Palliative Care created Honoring Choices Florida in 2013 in partnership with local hospitals. Community Hospice oversees and coordinates the program. Its role is to unite community organizations and health providers to create a standard and process for access to advance care planning.

What types of medical choices can I consider during advance care planning?

One of the most important decisions you should make is to identify the person you would want to speak on your behalf and make decisions for you if you are unable to do so. This is your *surrogate*. You can also decide if you do or do not want measures to prolong your life, such as cardiopulmonary resuscitation (CPR), artificial ventilation (respirator), artificial nutrition and hydration (tube feeding and IV fluids), renal dialysis and other interventions.

Who should I include in the advance care planning process?

People who participate in advance care planning should include the person chosen to be your health care surrogate, family members, other people important to you and your doctor, especially if you already have a serious or life-limiting illness. These people also should understand what is in your plan, when you make changes to your plan and what those changes are.

THIS DOCUMENT HAS 5 PARTS:

This document serves as your health care surrogate designation and your living will. The document pages are white and are on the right and are numbered 1 – 4. The direction pages are shaded and are on the left and not numbered.

PART 1 **MY HEALTH CARE DIRECTIVE:** Your identifying information.

PART 2 **HEALTH CARE SURROGATE DESIGNATION:** Identifies some duties of a surrogate, allows you to indicate when your surrogate's authority becomes effective and provides the opportunity to identify a primary and two alternate surrogates.

PART 3 **LIVING WILL AND HEALTH CARE INSTRUCTIONS:** Identifies some common care options and allows you to choose those options you would and would not want if you meet specific medical criteria.

PART 4 **COMMENTS AND ADDITIONAL INSTRUCTIONS:** Space is provided for you to write any specific instructions based on your personal, cultural, religious or spiritual preferences.

PART 5 **LEGAL AUTHORITY:** Signature page for you and two witnesses. Your health care surrogate cannot witness and one witness cannot be your spouse or a blood relative.

IMPORTANT THINGS TO NOTE ABOUT COMPLETING YOUR HONORING CHOICES FLORIDA DOCUMENT:

1. Print or write legibly using blue or black ink so your document can be read and easily copied.

2. If you make a mistake, either start over using another document or draw a single line through the error, make the correction, initial and date by the error.

3. If you have instructions that are longer than the directive allows space for, you may attach additional pages. If you do this, write a note in section 4 that additional pages are added and sign and date each additional page.

4. All reference documents noted in this booklet can be found at **HonoringChoicesFL.com** under the *Resources* tab.

5. The spaces labeled *Bar Code* and *Patient Label* at the bottom of each numbered page are for your health providers' use. You do not need to do anything in those areas.

When making copies of your document, only the white numbered pages need to be copied.

DO NOT WRITE ON THIS PAGE

Instructions for page 1 of 5

PART 1: MY HEALTH CARE DIRECTIVE

On the white page to the right, print your legal name, date of birth, address and phone numbers.

PART 2: HEALTH CARE SURROGATE DESIGNATION

The white page to the right outlines the legal rights and responsibilities of your surrogate. You may add to these responsibilities on page 4 of your directive.

In Florida, your surrogate's responsibilities begin when your doctor determines you cannot make health care decisions for yourself UNLESS you specify differently.

- Initial the first blank if you want your surrogate to have access to health information while you still have mental capacity.

- Initial the second blank if you want your surrogate to be able to make your health care decisions while you still have mental capacity. Keep in mind that if you select this option, you and your surrogate may make different decisions. If that happens, your wishes will be honored and not your surrogate's.

If you want your surrogate's authority to begin when a doctor says you cannot make your own decisions, do **not** initial either blank and draw a line through both sentences.

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FLORIDA

PART 1: MY HEALTH CARE DIRECTIVE

I have created this document with much thought to indicate my treatment choices and personal preferences, if I cannot communicate my wishes or am unable to make my own health care decisions. Any document created before this is no longer legal or valid. I understand that I need to complete a separate document if I want my surrogate to have authority to make decisions for me related to electroshock or psychosurgery, sterilization, pregnancy termination and/or experimental treatments.

My name: _____ **My date of birth:** _____

My address: _____

Telephone numbers (Primary): _____ **(Secondary):** _____

PART 2: HEALTH CARE SURROGATE DESIGNATION

If I am unable to communicate my wishes and health care decisions, or if my physician has determined that I am unable to make my own health care decisions, I choose the person(s) named on page 2 of this document to express my wishes and make my health care decisions. My surrogate may:

- Access my health information and talk with my health care providers.
- Authorize treatment or have it withheld or withdrawn based on my wishes.
- Authorize release of my health information to appropriate health care providers.
- Authorize admission, discharge or transfer to care facilities.
- Make decisions about organ and tissue donations based on my wishes.
- Apply for benefits on my behalf.

My health care surrogate's authority becomes effective when my physician determines that I am unable to make my own decisions ***unless*** I initial one or both statements below.

If I initial here _____ my health care surrogate's authority to receive my health information takes effect immediately.

If I initial here _____ my health care surrogate's authority to make health care decisions for me takes effect immediately. Any decisions I make while I have capacity will supersede any instructions or decisions made by my surrogate that are in conflict with those made by me.

Barcode:

Hospital Label

DO NOT WRITE ON THIS PAGE

Instructions for page 2 of 5

This page is where you identify the person/people you would want to speak for you if you are unable to make your own decisions. It is very important that you discuss your wishes with them to be sure they understand their role and are willing to accept it.

Complete each section with names, relationships, phone numbers and addresses.

We recommend that you select only one person to be your primary surrogate. If you find it difficult to choose between two or more people to serve as your primary surrogate, consider selecting the one who lives closest to you as your primary surrogate and the others as alternates. You can then add a written note on page 4 of your document that you expect them to work together to make decisions. There is also space on the document to name a second alternate. If you don't choose two alternates, put an X through any left blank.

Your surrogate(s) must be 18 years of age or older and cannot be a health provider or employee of a health care facility taking care of you unless you are related to that person by blood, marriage, domestic partnership or adoption.

If you choose your spouse as surrogate, Florida law requires that you indicate whether or not you want that person to continue as your surrogate if your marriage is in the process of being terminated or has ended. Initial by *yes* or *no*, depending on your wishes, or initial by *NA* if you do not choose your spouse as your surrogate.

You will find the *Health Care Surrogate Guide* and the *Advance Care Planning Conversation Guide* at **HonoringChoicesFL.com**. These fact sheets provide tips about how to choose a surrogate and how to initiate an advance care planning conversation.

I understand that my health care surrogate must be at least 18 years of age and cannot be a health care provider or employee of a health care provider giving direct care to me unless I am related to that person by blood or marriage, domestic partnership or adoption.

MY PRIMARY (MAIN) HEALTH CARE SURROGATE

Name: _____ **Relationship:**_____

Telephone numbers: (Primary) _____ **(Secondary)** _____

Address:_____

If I cancel my primary surrogate's authority, or if they are not willing, able or reasonably available to make a health care decision for me, I name as my first alternate surrogate:

1ST ALTERNATE HEALTH CARE SURROGATE

Name: _____ **Relationship:**_____

Telephone numbers: (Primary) _____ **(Secondary)** _____

Address:_____

If I cancel my primary and first alternate surrogates' authority, or if they are not willing, able or reasonably available to make a health care decision for me, I name as my second alternate surrogate:

2ND ALTERNATE HEALTH CARE SURROGATE

Name: _____ **Relationship:**_____

Telephone numbers: (Primary) _____ **(Secondary)** _____

Address:_____

If I have chosen my legal spouse as my primary or alternate surrogate, I want this person to continue as my surrogate if dissolution, annulment or termination of our marriage is in process or has been completed.

Initial one: **Yes**_____ **No**_____ **NA**_____

Barcode:

Hospital Label

DO NOT WRITE ON THIS PAGE

Instructions for page 3 of 5

PART 3: LIVING WILL AND HEALTH CARE INSTRUCTIONS

As long as you can speak for yourself, you will be asked to make your health care decisions. If a time comes when you cannot speak for yourself, the person you name as surrogate will be asked to make decisions on your behalf. Remember, your written wishes are only considered if you cannot speak for yourself AND if you have one of the three medical conditions.

Initial in the blank by each medical condition for which you want your preferences honored.

Next, we ask you think about your care preferences if you have one of the medical conditions.

For each treatment listed, circle *I Want* or *I Do Not Want* depending on your preferences. If you have any special instructions about these care preferences, write them in part 4 on the next page of this document.

You also have the opportunity to decide whether or not you want to be an organ donor.

Initial on the first line if you want to donate your organs. Initial on the second line if you do not want to donate your organs.

You will find fact sheets about each of these care preferences and organ donation at **HonoringChoicesFL.com.**

PART 3: LIVING WILL AND HEALTH CARE INSTRUCTIONS

I understand that my preferences indicated below will apply **ONLY** if I become unable to communicate or make my own decisions **AND** if two physicians have determined that I have at least one of the following medical conditions (initial all that apply):

If I initial here _____ I want my wishes honored if I have a **TERMINAL CONDITION** (condition caused by injury, disease or illness from which there is no reasonable medical probability of recovery and that, without treatment, can be expected to cause death).

If I initial here _____ I want my wishes honored if I have an **END-STAGE CONDITION** (an irreversible condition that is caused by injury, disease or illness that has resulted in progressively severe and permanent deterioration and for which, to a reasonable degree of medical probability, treatment of the condition would be ineffective).

If I initial here _____ I want my wishes honored if I am in a **PERSISTENT VEGETATIVE STATE** (permanent and irreversible condition of unconsciousness in which there is the absence of voluntary action or cognitive behavior of any kind and an inability to communicate or interact purposefully with the environment).

My wishes and preferences for my health care are noted below and I want my surrogate and health care providers to follow these choices **if I cannot speak for myself AND if I have one of the above conditions.**

Care Preferences	Circle Your Choice Below	
Cardiopulmonary Resuscitation (CPR)	**I Want**	**I Do Not Want**
Respirator / Ventilator (Breathing Tube)	**I Want**	**I Do Not Want**
Tube Feedings	**I Want**	**I Do Not Want**
IV Hydration	**I Want**	**I Do Not Want**
Dialysis	**I Want**	**I Do Not Want**
Hospice and Palliative Care	**I Want**	**I Do Not Want**

ORGAN/TISSUE DONATION

If I initial here _____ I do want to donate my eyes, tissues and/or organs, if able.

OR

If I initial here _____ I do not want to donate my eyes, tissues and/or organs.

If I have specific instructions, I have written them in part 4 on page 4.

There may be situations in which my treatment preferences may not be followed, based on Florida law and/or a provider's mission or policies, and my surrogate or I may request a transfer to another provider.

Barcode:

Hospital Label

Instructions for page 4 of 5

PART 4: COMMENTS AND ADDITIONAL INSTRUCTIONS (OPTIONAL)

This section is where you can add additional notes and wishes, such as duties of your surrogate, other care preferences and any preferences based on your cultural, religious or personal beliefs.

Examples of some things others have written here include preferences about:

- Pain medication related to level of awareness
- Alternative therapies
- Time limits and trial periods for care options
- Where you would prefer to spend your last days, such as in a hospital, nursing home or at home, with or without hospice care
- The type of music you would like playing in the background
- Who you would like at your bedside and if you would like support from your spiritual or faith leader
- Final arrangements, such as burial vs. cremation, and memorial service details
- Designations for gifts and donations following death

You may have some personal wishes to add. If space does not allow for all of your comments, you can add another page of notes to your document. If you do this, write a note on the last line that an additional page has been added and sign and date the additional page.

You do not have to write anything if nothing comes to mind. If you do not add any notes in this section, draw an X through part 4.

PART 4: COMMENTS AND ADDITIONAL INSTRUCTIONS (OPTIONAL)

I have written the following specific instructions and ask my surrogate, family members and health care providers to follow my wishes. ***If none, draw X through this section.***

Barcode:

Hospital Label

Instructions for page 5 of 5

PART 5: LEGAL AUTHORITY

To be considered a legal document, you must sign and date this page in front of two witnesses. Everyone must sign on the same date. Witnesses must see you sign your document. Your witnesses do not need to see the previous pages and they do not need to know your wishes. Their signatures confirm that they watched you sign your document.

The people you named as surrogate(s) cannot witness. One witness must be someone other than your spouse or a blood relative.

You sign on the line above *signature*, print your name and put the date and time. The two witnesses will do the same, below your signature, and will add their addresses.

Your document does not have to be notarized.

PART 5: LEGAL AUTHORITY

I have made this document willingly, I am thinking clearly and this document expresses my decisions about my future health care treatment:

Signature	Print Name	Date	Time

Witness 1 Signature	Print Name	Date	Time

Address	Phone

Witness 2 Signature	Print Name	Date	Time

Address	Phone

Your health care surrogate(s) cannot serve as a witness to this document. At least one witness must be someone other than your spouse or blood relative.

Barcode:

Hospital Label

In addition to your health surrogate and alternate health surrogates, identify where copies of this advance health directive will be stored and with whom:

DOCTORS

Name:_____ Contact Info:_____

Name:_____ Contact Info:_____

Name:_____ Contact Info:_____

HOSPITALS

Name:_____ Contact Info:_____

Name:_____ Contact Info:_____

OTHERS (SUCH AS FAMILY MEMBERS, FRIENDS, CLERGY)

Name:_____ Contact Info:_____

Name:_____ Contact Info:_____

Name:_____ Contact Info:_____

NEXT STEPS FOLLOWING COMPLETION OF DOCUMENT

Now that you have completed your health care directive, you should also take the following steps:

Talk to the person you name as your health care surrogate, if you haven't already done so. Make sure your surrogate feels that he/she is able to perform this important job for you in the future.

Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care surrogate is and what your wishes are.

Make sure your wishes are understood and will be followed by your doctor and other medical providers.

Keep a copy of your health care directive where it can be easily found.

If you go to a hospital or nursing home, take a copy of your health care directive and ask that it be placed in your medical record.

Review your health care wishes every time you have a physical exam or whenever any of the *Five Ds* occur:

Decade:	When you start each new decade of your life.
Death:	Whenever you experience the death of a loved one.
Divorce:	When you experience a divorce or other major family change.
Diagnosis:	When you are diagnosed with a serious health condition.
Decline:	When you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.

DOES AN ADVANCE DIRECTIVE MEAN "DO NOT TREAT"?

Your advance directive should indicate both the treatment you *would* want and the treatment you *would not* want.

IF I NAME A HEALTH CARE SURROGATE, DO I GIVE UP THE RIGHT TO MAKE DECISIONS FOR MYSELF?

Naming a surrogate does not take away your ability to make your own decisions. As long as you are capable, you always have the right to make your own decisions or to revoke your directive.

IS ADVANCE CARE PLANNING JUST FOR THE ELDERLY OR PEOPLE IN POOR HEALTH?

Advance care planning is actually for all adults, regardless of their age or health status. A sudden accident or illness could cause you to be unable to make health care decisions for yourself, so have the conversation today. Make sure your family and health providers know what care you would want if you are faced with a sudden injury or illness.

HOW ARE DECISIONS MADE IF I CAN'T SPEAK FOR MYSELF AND I HAVE NOT NAMED A HEALTH CARE SURROGATE?

Your medical provider will assign a *proxy* to make your decisions when you can't speak for yourself. In Florida, they must follow a hierarchy to choose the proxy, at times requiring a majority of your family members to agree and make decisions. This often ends up in disagreements and additional stress for your loved ones.

CAN I GET HELP WITH ADVANCE CARE PLANNING?

This is what makes Honoring Choices Florida different from other advance care directives you may have seen: getting help is part of the plan! We offer a team of trained facilitators who are experts in guiding these conversations. One will meet with you and your family at a time and place convenient for you and guide you in a conversation about your values, goals and experiences. Best of all, this is available at no cost to you if you live in one of the 16 counties in Northeast and North Central Florida. To inquire about the availability of a facilitator, make an appointment, ask a question or request copies of this booklet, call **904.407.7024** or visit **HonoringChoicesFL.com.**

Once you have completed an advance care plan and shared copies with those close to you, complete the wallet card below, cut it out and keep it with important documents you carry at all times, such as your photo ID and health insurance card.

It is important for you to complete the information on both sides of the wallet card. *Cut the card out and keep it in your wallet.*

Honoring Choices® FLORIDA

My name: _____

Date of birth: _____

I have an advance care plan dated: _____
It is on file with:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Honoring Choices®
FLORIDA

Community Hospice & Palliative Care
4266 Sunbeam Road
Jacksonville, FL 32257

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An advance care planning initiative led by Community Hospice & Palliative Care

904.407.7024
HonoringChoicesFL.com

A 2013 review of patient deaths at several Northeast Florida hospitals revealed fewer than 14 percent of patients had an advance directive in their medical record.

At Honoring Choices Florida, we know that's not good enough.

We've partnered with area health systems to find a better way. Together, we're helping people have important conversations about their health care wishes.

We're ready to partner with you and your loved ones, too. Let's have a conversation.

Honoring Choices Florida is a program of Community Hospice & Palliative Care. This program is provided solely through generous philanthropic support. To make a gift to the program, call Community Hospice & Palliative Care Foundation at **904.886.3883** or visit **Support.CommunityHospice.com.**

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My health care surrogate is:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ (home)

_____ (work)

_____ (mobile)

It is important for you to complete the information on both sides of the wallet card. *Cut the card out and keep it in your wallet.*