MY
FIRST CHOICE
FOR HEALTH CARE

Give Voice to your Choice

ADVANCE DIRECTIVE WORKBOOK

*** Completing this workbook is the first step you can take to protect your right to have your preferences respected when you are unable to communicate them. IT IS NOT A LEGAL DOCUMENT ***

Connecticut Legal Rights Project, Inc.
April, 2014

ADVANCE DIRECTIVES GIVE VOICE TO YOUR CHOICE

This workbook was developed by the Connecticut Legal Rights Project to help you prepare a legal document called an advance directive. An advance directive allows you to influence your health care treatment when you are unable to do so.

Judges, hearing officers and conservators must consider your choices and respect the preferences in your advance directive when making decisions about your treatment.

CLRP has three flyers on this topic that can help:

Basics of Advance Directives for Health Care
Choosing a Health Care Representative
How to Be an Effective Health Care Representative

This workbook is NOT a legal document. It collects information that will be used by lawyers at CLRP to prepare your advance directive.

If you have questions about this workbook or advance directives, call CLRP at 1-877-402-2299 or go to CLRP's website at www.clrp.org.

WHY TAKE THE TIME TO DO AN ADVANCE DIRECTIVE?

Advance Directives have helped others…They can help you.

"I was tired of my family always having control over my life. I wanted to have choices. I wanted to have a say in my life. Advance directives are a very beneficial tool. I feel people should take the time to make them because you never know what life may throw you." Leslie E.

"It allows loved ones not to have to make difficult decisions when faced with end of life emotions."

Charles E.

My Workbook:

- **Name:** _____

Address: _____

_____

Telephone Numbers: _____

Name of person (if any) who helped with completing this workbook:

_____

Date Completed: _____

Date called CLRP @ 877-402-2299: _____

Assistance is available to help you understand and prepare an advance directive. Contact CT Legal Rights Project to have your questions answered by an attorney or paralegal. An advance directive is a legal document and we strongly encourage you to obtain legal advice when completing, updating or revoking one.

MY HEALTH CARE CHOICES

The sections of this workbook cover a number of different topics related to your health care. **You do not need to complete every section. It is your choice**

If you have previously completed an advance directive and want to change all or part of it, please complete the section below.

1. REVOKING AN ADVANCE DIRECTIVE:

Do you currently have an advance directive?

☐ **Yes** ☐ **No**

I want to make the following changes:

_____ I want to revoke the appointment of:

_____

as my Health Care Representative in my advance directive dated: _____.

_____ I also want to revoke the appointment of:

_____

as my Alternate Health Care Representative in my advance directive dated: _____.

_____ Revoke my Health Care Instructions; or

_____ Keep my Health Care Instructions, and only make changes specified above

It's a good idea to contact your previously appointed Health Care Representative and Alternate to inform them of your decision to revoke their authority in you new advance directive.

NOTE: If the individual does not have a copy of the previous advance directive and CLRP does not have it on file, a new set of health care instructions must be completed.

2. APPOINTMENT OF DECISION MAKERS:

I, _____, appoint the following:

¤ APPOINTMENT OF HEALTH CARE REPRESENTATIVE:

If my attending physician determines that I am not able 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:

> Make any and all health care decisions for me, including the decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical condition, except as otherwise provided by law, including, but not limited to, psychosurgery or shock therapy, and 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 this document 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 a decision in my best interests, based upon what is known of my wishes.

I appoint _____ to be my health care representative.

Telephone number: _____

Address: _____

¤ APPOINTMENT OF ALTERNATE HEALTH CARE REPRESENTATIVE:

I appoint _____ to be my alternate health care representative.

Telephone number: _____

Address: _____

¤ I DO NOT CHOOSE TO APPOINT A HEALTH CARE REPRESENTATIVE AT THIS TIME:

I do not have a Health Care Representative but I want this document to serve as a legal testament of my wishes.

My Emergency Contact Person is: _____

Telephone Number: _____

Address: _____

¤ DESIGNATION OF CONSERVATOR OF PERSON, IF NEEDED:

If a conservator of person should need to be appointed, I designate

_____ to be appointed my conservator.

If my first preference is unwilling or unable to serve as my conservator of person, I designate _____ to be appointed my conservator.

¤ DESIGNATION OF CONSERVATOR OF ESTATE, IF NEEDED:

If a conservator of estate should need to be appointed, I designate

_____ to be appointed my conservator.

If my first preference is unwilling or unable to serve as my conservator of estate, I designate _____ to be appointed my conservator.

No bond shall be required of any proposed conservator in any jurisdiction.

3. HEALTH CARE INSTRUCTIONS:

¤ HOSPITALS OR PROGRAMS/FACILITIES WHERE I PREFER TO BE ADMITTED:

Facility's Name: _____
Reason (optional): _____
_____

Facility's Name: _____
Reason (optional): _____
_____

Facility's Name: _____
Reason (optional): _____
_____

¤ HOSPITALS OR PROGRAMS/FACILITIES WHERE I PREFER NOT TO BE ADMITTED:

Facility's Name: _____
Reason (optional): _____
_____

Facility's Name: _____
Reason (optional): _____
_____

Facility's Name: _____
Reason (optional): _____
_____

▫ PHYSICIAN(S) I PREFER TO TREAT ME IF I AM HOSPITALIZED:

Dr. _____ Phone # _____
Address: _____
Type of Practice: _____

Dr. _____ Phone # _____
Address: _____
Type of Practice: _____

Dr. _____ Phone # _____
Address: _____
Type of Practice: _____

Dr. _____ Phone # _____
Address: _____
Type of Practice: _____

Dr. _____ Phone # _____
Address: _____
Type of Practice: _____

▫ PHYSICIAN(S) I PREFER NOT TREAT ME:

Dr. _____ Phone # _____
Reason: (optional) _____

Dr. _____ Phone # _____
Reason: (optional) _____

Dr. _____ Phone # _____
Reason: (optional) _____

Dr. _____ Phone # _____
Reason: (optional) _____

◘ MEDICATIONS I PREFER FOR HEALTH CARE TREATMENT:

List your medication preferences here or insert a medication printout from your provider.

	Medication Preference	Dosage Range Preference
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

◘ MEDICATIONS I DON'T WANT: I specifically do not want and do not want my Health Care Representative to consent to the administration of the following medications or their respective brand-name, trade-name, or generic equivalents:

Name of drug: _____
Reason: (optional) _____

Name of drug: _____
Reason: (optional) _____

Name of drug: _____
Reason: (optional) _____

◘ OTHER COMMENTS REGARDING MEDICATION:

_____

_____

_____

▫ ELECTROSHOCK TREATMENT: (electroconvulsive therapy or ECT):

In Connecticut, a person who cannot give informed consent can only receive ECT (electroconvulsive therapy or shock treatment) if a Probate Court orders it. I want the Probate Court to consider my preference as documented in my Advance Directive.

My preference regarding the administration of ECT is:

_____ If recommended, I have no objection to the administration of ECT of the following type:

_____

_____ If recommended, I prefer the number of treatments to be: (initial one)

_____ determined by my attending physician.

_____ approved by: _____

_____ as follows: _____

Reason: (optional) _____

_____ I *do not want* the administration of ECT (electroconvulsive therapy or electroshock therapy).

Reason: (optional) _____

_____ I do not have a preference.

▫ APPROACHES THAT HELP WHEN I'M HAVING A HARD TIME:

If I'm having a hard time, the following approaches are helpful to me (yes or no):

_____ Time in my room
_____ Arts and crafts
_____ Taking a shower
_____ Talking with a peer
_____ Having my hand held
_____ Going for a walk
_____ Punching a pillow
_____ Writing in my journal
_____ Deep breathing exercises
_____ Talking with staff
_____ Offer me a nicotine substitute
_____ Other: _____
_____ Other: _____

_____ Listening to music
_____ Reading
_____ Watching TV
_____ Pacing the halls
_____ Calling a friend
_____ Calling my therapist
_____ Meditation
_____ Lying down
_____ Sitting by staff
_____ Exercising
_____ Offer me medication

▫ PEOPLE I WANT NOTIFIED IF I'M HOSPITALIZED:

Please assist me in contacting the following people:

Name: _____ Phone #: _____
Address: _____
Relationship: _____
This person helps me when I'm upset: _____Yes _____No
I want this person to visit me: _____Yes _____No

Name: _____ Phone #: _____
Address: _____
Relationship: _____
This person helps me when I'm upset: _____Yes _____No
I want this person to visit me: _____Yes _____No

Name: _____ Phone #: _____
Address: _____
Relationship: _____
This person helps me when I'm upset: _____Yes _____No
I want this person to visit me: _____Yes _____No

Name: _____ Phone #: _____
Address: _____
Relationship: _____
This person helps me when I'm upset: _____Yes _____No
I want this person to visit me: _____Yes _____No

▫ PHYSICAL CONTACT BY STAFF:

It's okay if staff touches me? _____ (yes or no)
Comment: (i.e., type of contact that is helpful (holding my hand, touching my shoulder, etc., or why you don't want to be touched.)

¤ THINGS THAT MAKE IT MORE DIFFICULT WHEN I'M ALREADY UPSET:

(yes or no)
_____ Being touched
_____ Being isolated
_____ Bedroom door open
_____ People in uniform
_____ Time of year _____
_____ Time of day _____
_____ Yelling
_____ Loud noise
_____ Not having control/input with _____
_____ Other: _____
_____ Other: _____

¤ EMERGENCY INVOLUNTARY TREATMENTS:

Any medications listed in this section are my choices for emergency situations only. (Give 1 to your first choice, 2 to your second, and so on until your preferences have a number.)

_____ Seclusion
_____ Physical restraints
_____ Medication by injection: _____
_____ Medication in pill form: _____
_____ Liquid medication: _____
_____ Other: _____
_____ Other: _____

¤ PREFERENCES REGARDING THE USE OF RESTRAINTS AND SECLUSION:

_____ In the past, I've found the following helpful during a restraint:
_____
_____

_____ I have never been in restraints.

¤ DURING SECLUSON AND/OR RESTRAINT, I PREFER TO BE CHECKED BY:

_____ Female staff
_____ Male staff
Reason for choice: (optional) _____
_____
_____ No preference.

¤ CONSENT FOR STUDENT EDUCATION, TREATMENT STUDIES, OR DRUG TRIALS:

_____ I authorize my Health Care Representative to consent to my participation in:

_____ Student education
_____ Treatment studies
_____ Drug Trials

My Health Care Representative will consult with my treating physician, and any other individuals my Health Care Representative may think appropriate, determine that the potential benefits to me outweigh the possible risks of my participation and that other, non-experimental interventions are not likely to provide effective treatment. This consent is not intended to substitute for any other consent required by law.

_____ I do not wish to participate in student education, treatment studies, or drug trials.

_____ No preference

¤ WHERE I PREFER TO RECEIVE OUTPATIENT TREATMENT UPON DISCHARGE:

Provider: _____
Reason: (optional) _____
_____

Provider: _____
Reason: (optional) _____
_____

◘ WHERE I PREFER NOT TO RECEIVE OUTPATIENT TREATMENT:

Provider: _____

Reason: (optional) _____

_____

Provider: _____

Reason: (optional) _____

_____

◘ ADDITIONAL PREFERENCES REGARDING MY HEALTH CARE TREATMENT: (You may want to insert your WRAP here)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

4. LIVING WILL

(END OF LIFE) DECISIONS:

◘ MY WISHES REGARDING LIFE SUPPORT:

If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a testament of my wishes.

_____ **I do not want to make a decision at this time** regarding the termination of life support and I understand that extreme measures may be taken to keep me alive.

_____ I want all measures taken to keep me alive.

_____ I've made decisions regarding the termination of life support in a separate Living Will located at: _____

_____ **I request that, if my condition is deemed terminal or if it is determined that I will 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. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged. This request is made, after careful reflection, while I am of sound mind.

The life support systems which **I do not want** include, but are not limited to:

____ Artificial respiration (i.e., oxygen, breathing machine)

____ Cardiopulmonary resuscitation (i.e., CPR, heart restarted)

____ Artificial means of providing nutrition and hydration (i.e., IV, feeding tube)

NOTE: This is not the same as a DNR (Do Not Resuscitate order).

Please speak to your health care provider regarding this.

¤ STATEMENT OF ANATOMICAL GIFT:

I hereby make this anatomical gift, if medically acceptable, to take effect upon my death.

I give:

_____ Any needed organs or parts.

_____ Only the following organs or parts: _____

_____

To be donated for:

_____ Any of the purposes stated in subsection (a) of the section 19a-279f of the general statutes, including education, research, and transplantation and therapy.

_____ These limited purposes: _____

_____

Or:

_____ *I am an organ donor on my driver's license/state issued ID.*

_____ *I do not want to make an anatomical gift.*

_____ *I do not want to make a decision at this time.*

¤ OTHER SPECIFIC END OF LIFE REQUESTS:

_____

_____

_____

_____

_____

_____

5. RELEASES

If you want to include a release of medical information for your Health Care Representative, please provide the following information:

NAME: _____

DATE OF BIRTH: _____

My Health Care Representative: _____.

If you want to include a release of medical information for your Alternate Health Care Representative, please provide the following information:

Name: _____

Date of Birth: _____

Alternate Health Care Representative:_____.

If you want to include a release of medical information for your Emergency Contact Person, please provide the following information:

Name: _____

Date of Birth:_____

Emergency Contact Person: _____

If you want to include a release of medical information for CT Legal Rights Project, please provide the following information:

Name: _____

Date of Birth:_____

6.OTHER IMPORTANT INFORMATION:

¤ IF I AM HOSPITALIZED, I HAVE THE FOLLOWING RESPONSIBILITIES (Child, Pet, Apartment, etc.):

Responsibility: _____

Please contact the following person about this responsibility:
Name: _____ Relationship: _____
Phone #s: _____
Address: _____

If person named above is unavailable, please contact:
Name: _____ Relationship: _____
Phone #s: _____
Address: _____

Additional information regarding my responsibility: _____
_____
_____

Responsibility: _____

Please contact the following person about this responsibility:
Name: _____ Relationship: _____
Phone #s: _____
Address: _____

If person named above is unavailable, please contact:
Name: _____ Relationship: _____
Phone #s: _____
Address: _____

Additional information regarding my responsibility: _____
_____
_____
_____
_____
_____

▫ ENFORCEMENT: I, _____, grant my Health Care Representative permission to contact the Office of Protection and Advocacy, CT Legal Rights Project, Inc., and/or any other attorney the authority to enforce compliance with implementation of my advance directive.

▫ LOCATION OF THIS DOCUMENT:

The original of this document will be kept by: _____
at: _____

The following persons and/or facilities will have a copy:

Name or facility: _____ Phone #: _____
Address: _____

Name or facility: _____ Phone #: _____
Address: _____

Name or facility: _____ Phone #: _____
Address: _____

Name or facility: _____ Phone #: _____
Address: _____

Name or facility: _____ Phone #: _____
Address: _____

Name or facility: _____ Phone #: _____
Address: _____

Name or facility: _____ Phone #: _____
Address: _____

Name or facility: _____ Phone #: _____
Address: _____

7. OPTIONAL PROVISIONS

¤ STATEMENT OF PATIENT ADVOCATE, HOSPITAL REPRESENTATIVE, OR AUTHORIZED PERSON:

If you are given assistance from an employee of a health care facility when completing this document, ask the person giving you assistance to complete the following information.

The following person explained the nature and effect of this Advance Directive.

Printed name: _____

Title: _____ Date: _____

Facility: _____ Location: _____

¤ IF MY SPOUSE IS MY HEALTH CARE REPRESENTATIVE:

If your spouse is designated as your Health Care Representative, the appointment will be revoked upon legal separation, divorce, or annulment unless you complete this section.

I, _____, desire the person I have named as my Health Care Representative, who is now my spouse, to remain my Health Care Representative even if we become legally separated or our marriage is dissolved.

8. Wallet Card:

_____ I want CLRP to provide me with a laminated wallet card to inform providers who to contact in an emergency and the location of my advance directive.

IMPORTANT REMINDER

Remember that advance directives can only be used when a doctor has determined that you are unable to make or communicate your decisions about treatment.

IT IS IMPORTANT THAT:

- People know they have been named in your advance directive
- They understand your preferences
- They have copies of your advance directive or know where to get one.

YOU COMPLETED YOUR WORKBOOK. NOW IT'S TIME TO PREPARE AN ADVANCE DIRECTIVE!

You Should:

1. TALK TO PEOPLE YOU APPOINTED. Talk to the people you named in your Workbook to make sure they are willing to accept the responsibility of being a decision maker for you and that they understand and will respect your preferences. You may also want to discuss your preferences with your case manager and treatment providers.

2. CALL CLRP.

If CLRP is not currently representing you on your advance directive, contact CLRP at 860-262-5030 or 1-877-402-2299 for an intake. CLRP will:

1. Review it with you to answer any of your questions and finalize the legal document;
2. Oversee execution of the document (have you sign the document with two witnesses and a notary present);
3. Distribute it according to your wishes;
4. Provide you with a laminated wallet card;
5. Maintain a copy of your advance directive on file; and
6. Send annual reminders to review your advance directive and update your releases, which expire after one year.

3. REVIEW YOUR ADVANCE DIRECTIVE ANNUALLY

- Your advance directive can last forever. However, some of your preferences may change over time.
- Your health care instructions concerning any aspect of health care, including the withholding or withdrawal of life support systems, may be revoked at any time and in any manner without regard to your mental status. If you want to revoke your appointment of health care representative, you must do it in writing and have it witnessed.

Mission Statement

Connecticut Legal Rights Project, Inc., (CLRP) is a statewide non-profit agency which provides legal services to low income persons with psychiatric disabilities, who reside in hospitals or the community, on matters related to their treatment, recovery, and civil rights. CLRP represents clients in accordance with their expressed preferences in administrative, judicial, and legislative venues to enforce their legal rights and assure that personal choices are respected and individual self-determination is protected. CLRP develops and supports initiatives to promote full community integration which maximizes opportunities for independence and self-sufficiency.

CLRP represents clients on a range of issues related to their treatment, recovery and civil rights. These include involuntary medication, discharge, community integration, housing, employment, education, disability benefits, advance directives and conservatorships.

For additional information contact:

CONNECTICUT
LEGAL
RIGHTS
PROJECT, INC.

CT Legal Rights Project, Inc.
P.O. Box 351, Silver Street
Middletown, CT 06457
1-877-402-2299

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9. Questions for the Attorney

_____ I have no questions for the attorney

_____ I have the following questions for the attorney:

1._____
_____

2._____
_____

3._____
_____

4._____
_____

5._____
_____