NORTHSIDE HOSPITAL

Atlanta • Forsyth • Cherokee

GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

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Advance Directives: "Your Right To Decide"

Georgia law gives competent adults the right to make choices about their own health care. This includes the right to choose medical care, to refuse certain care or to stop care altogether. Georgia law also lets you choose someone to make health care choices for you if you unable or unwilling to do so.

The best way for you to be in control of your medical treatment is to sign a *'Georgia Advance Directive For Health Care'* before you have an illness that prevents you from communicating your wishes.

What is an '*Advance Directive*'?
An advance directive is a legal form that lists your wishes about medical care and treatment. You may also name someone to make choices about your medical care and treatment if you can't. These forms are called advance directives since they are written in advance of a serious illness, to let other people know your wishes.

Before July 1, 2007, Georgia law recognized two kinds of 'advance directives': a *Living Will* and a *Durable Power of Attorney for Health Care.*

Recent changes in Georgia law combined these two forms into one simple form called ***'Georgia Advance Directive For Health Care'.***

What happens if I completed a Living Will or Durable Power of Attorney for Health care before the new law?
An advance directive that was completed before the change in Georgia law is still legal. You may change to the new form at any time, but you do not have to do so.

Do I have to have an advance directive?
No. Federal law makes it against the law for a hospital to refuse to take care of you because you do not have an advance directive.

By law, the hospital must ask if you have an advance directive and give you information about state laws and hospital policy on advance directives.

What will happen if I decide not to have an advance directive?
As long as you are still alert and able to speak for yourself, you will be able to make your own decisions about your medical care.

If you are no longer able to make decisions and do not have an advance directive, Georgia law allows your closest relative to agree to treatment for you.

If I have an advance directive from another state, will it be honored at Northside?
Northside will honor an advance directive from another state if the advance directive also meets the requirements of Georgia law.

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What is the *'Georgia Advance Directive For Health Care'?*

The ***'Georgia Advance Directive For Health Care'*** is a legal document that you complete. It tells your doctor and your healthcare providers:

- PART I:
  How to choose a person to make decisions about your healthcare if you are unable or unwilling to do so. This person is called a 'health care agent'.

Who can I name as my 'health care agent'?
You may name any adult as your healthcare agent. Choose a person who knows about your wishes and whom you trust to carry out your wishes. If you name your spouse and then are divorced, the right of the ex-spouse to make decisions for you is automatically taken away when the divorce is final. The only person who cannot be your agent is your doctor or healthcare provider.

What will my 'health care agent' do?
Your health care agent will be able to make health care decisions for your care or treatment if you are unable or unwilling to do so. You may also choose for your health care agent to make decisions about organ and body donation and autopsies after you die.

What can't my 'health care agent' do?
Your agent would not be allowed to consent to psychosurgery, sterilization or hospitalization for mental illness or substance abuse. In addition, your physician can administer treatment for your comfort or to relieve pain without the permission of your agent.

May I ask more than one person to be my health care agent?
It is not a good idea to name more than one person to make decisions for you at the same time. This can cause problems if they do not agree about treatment choices. It would be wise, however, to name a second person in the event the primary person is unable or unwilling to do so at the time he or she is needed.

- PART II:
  How to direct healthcare providers as to what you want. If you do or do not want life-sustaining treatments if you become terminally ill or are in a permanent unconscious state you may so state in your advanced directive. These are treatments that will not cure your terminal illness or make you better, but they may postpone death. Some examples of these are cardiopulmonary resuscitation (CPR) to return your heart beat and breathing and putting you on a machine to help you breathe. You can also decide if you want to receive food or liquids by a tube if you cannot eat or drink

What is a terminal condition and permanent unconscious state?
A terminal condition is a condition that is incurable. Medical treatment will only postpone death, not make you better. Without treatment death may occur in a short time. A permanent unconscious state means that you are in an irreversible or incurable state and you are not aware of your surroundings or yourself.

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May I name particular treatments that I don't want?
If you want to name particular treatments that you would or would not want, you may do so. *For example, you may want to state your treatment preferences regarding medications to fight infection or provide pain relief, surgery, amputation, blood transfusion, or kidney dialysis.*

May I name particular treatments that I do want?
Yes. Some people feel that they would want everything possible done for them if there were any hope of keeping them alive.

- PART III:
  How to change the agent or the terms of the advance directive if you change your mind.

Can I change my mind after I write an advance directive?
You may change or cancel your advance directive at any time. This means you can change the terms or change your agent for health care decisions. To change your advance directive, tear up the original advance directive and complete a new form, have it signed and witnessed. Provide copies to your health care agent, doctor or healthcare provider, and relatives. If you want to cancel your advance directive, tear up the original and let your health care agent, doctor or healthcare provider, and relatives know that you have canceled your advance directive.

Will an advance directive always be followed?
Generally yes, if it complies with Georgia Law. If your health care provider is unable to follow your advance directives for moral, religious, or professional reasons, even though they comply with the Georgia Law, they must tell you or your agent right away. Then they must help make plans to transfer your care to another doctor or facility that is able to honor your wishes. In an emergency it may be impossible at the time to know your chances for survival or recovery. Once the emergency is over, your healthcare providers can better determine your condition and your advance directive will be looked at and followed.

If I am pregnant, will my wishes in my advance directive be carried out?
That depends. If the baby is developed enough that the baby could survive delivery, any instructions that would result in withholding or withdrawing life-sustaining treatments would not be honored. Even if the baby is not developed enough to survive delivery, your treatment choices would not be honored unless you initial the statement on the ***'Georgia Advance Directive For Health*** form that you want life sustaining treatment withheld or withdrawn when you are pregnant with a non-viable infant.

Is there a time limit on how long my advance directive will be legal?
There is no time limit on an advance directive.

Advance Directives: "Your Right To Decide"

After I complete the advance directive, what do I do with it?
Once you have completed your advance directive and it is properly signed and witnessed, make sure you give a copy to:

- Your health care agent
- Your doctor or health care provider
- Your relatives.
- You may also complete the ***'Georgia Advance Directive For Health Card*** included at the end of the form and keep it in your wallet. This card says that you have an advance directive and who to contact.

What is Northside Hospital's policy about advance directives?

- Northside Hospital will honor a patient's advance directive if it meets the requirements of Georgia law.
- Northside Hospital also recognizes and respects the right of competent patients to accept or refuse offered medical or surgical treatment, to the extent permitted by law.
- Northside Hospital's policy is that employees MAY NOT sign as a witness to any of these documents.

Do I need a lawyer to complete an advance directive?
No. The form provided is legal in Georgia if the directions on the form are followed.

Georgia Advance Directive
For Health Card
Directives I have completed: (check one or more as appropriate)
___ Part I Healthcare Agent
___ Part 2 Treatment Preferences
___ Part 3 Guardianship

Person to Contact:_____
Address:_____
City:_____State_____
Zip_____Phone_____
Date_____
Signature_____

Georgia Advance Directive
For Health Card
Directives I have completed: (check one or more as appropriate)
___ Part I Healthcare Agent
___ Part 2 Treatment Preferences
___ Part 3 Guardianship

Person to Contact:_____
Address:_____
City:_____State_____
Zip_____Phone_____
Date_____
Signature_____

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GEORGIA ADVANCE DIRECTIVE FOR HEALTH CARE

By: _____ Date of Birth: _____
(Print Name) (Month/Day/Year)

This advance directive for health care has four parts:

PART ONE **HEALTH CARE AGENT.** This part allows you to choose someone to make health care decisions for you when you cannot (or do not want to) make health care decisions for yourself. The person you choose is called a health care agent. You may also have your health care agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body. You should talk to your health care agent about this important role.

PART TWO **TREATMENT PREFERENCES.** This part allows you to state your treatment preferences if you have a terminal condition or if you are in a state of permanent unconsciousness. PART TWO will become effective only if you are unable to communicate your treatment preferences. Reasonable and appropriate efforts will be made to communicate with you about your treatment preferences before PART TWO becomes effective. You should talk to your family and others close to you about your treatment preferences.

PART THREE **GUARDIANSHIP.** This part allows you to nominate a person to be your guardian should one ever be needed.

PART FOUR **EFFECTIVENESS AND SIGNATURES.** This part requires your signature and the signatures of two witnesses. **You must complete PART FOUR if you have filled out any other part of this form.**

You may fill out any or all of the first three parts listed above. You must fill out PART FOUR of this form in order for this form to be effective.

You should give a copy of this completed form to people who might need it, such as your health care agent, your family, and your physician. Keep a copy of this completed form at home in a place where it can easily be found if it is needed. Review this completed form periodically to make sure it still reflects your preferences. If your preferences change, complete a new advance directive for health care.

Using this form of advance directive for health care is completely optional. Other forms of advance directives for health care may be used in Georgia.

You may revoke this completed form at any time. This completed form will replace any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that you have completed before completing this form.

PART ONE: HEALTH CARE AGENT

[PART ONE will be effective even if PART TWO is not completed. A physician or health care provider who is directly involved in your health care may not serve as your health care agent. If you are married, a future divorce or annulment of your marriage will revoke the selection of your current spouse as your health care agent. If you are not married, a future marriage will revoke the selection of your health care agent unless the person you selected as your health care agent is your new spouse.]

(1) HEALTH CARE AGENT

I select the following person as my health care agent to make health care decisions for me:

Name:_____

Address:_____

Telephone Numbers:_____

(Home, Work, and Mobile)

(2) BACK-UP HEALTH CARE AGENT

[This section is optional. PART ONE will be effective even if this section is left blank.]

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

(3) GENERAL POWERS OF HEALTH CARE AGENT

My health care agent will make health care decisions for me when I am unable to communicate my health care decisions or I choose to have my health care agent communicate my health care decisions.

My health care agent will have the same authority to make any health care decision that I could make. My health care agent's authority includes, for example, the power to:

- Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- Request, consent to, withhold, or withdraw any type of health care; and
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have

the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

I understand that under Georgia law:

- My health care agent may refuse to act as my health care agent;
- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and
- My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.

(4) GUIDANCE FOR HEALTH CARE AGENT

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

(5) POWERS OF HEALTH CARE AGENT AFTER DEATH

(A) AUTOPSY

My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent's power by initialing below.

_____ (Initials) My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) ORGAN DONATION AND DONATION OF BODY

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless I have limited my health care agent's power by initialing below.

[Initial each statement that you want to apply.]

_____ (Initials) My health care agent will not have the power to make a disposition of my body for use in a medical study program.

_____ (Initials) My health care agent will not have the power to donate any of my organs.

(C) FINAL DISPOSITION OF BODY

My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

_____ I want the following person to make decisions about the final disposition of my body:

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

I wish for my body to be:

_____ (Initials) Buried

OR

_____ (Initials) Cremated

PART TWO: TREATMENT PREFERENCES

[PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.]

(6) CONDITIONS

PART TWO will be effective if I am in any of the following conditions:
[Initial each condition in which you want PART TWO to be effective.]

_____ (Initials) A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

_____ (Initials) A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

My condition will be determined in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

(7) TREATMENT PREFERENCES

[State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.]

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

(A)_____ (Initials) Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

OR

(B)_____ (Initials) Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

OR

(C)_____ (Initials) I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:

[Initial **each statement** that you want to apply to option (C).]

_____ (Initials) If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.

_____ (Initials) If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.

_____ (Initials) If I need assistance to breathe, I want to have a ventilator used.

_____ (Initials) If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

(8) ADDITIONAL STATEMENTS

[This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.]

_____

_____

_____

(9) IN CASE OF PREGNANCY

[PART TWO will be effective even if this section is left blank.]

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

_____ (Initials) I want PART TWO to be carried out if my fetus is not viable.

PART THREE: GUARDIANSHIP

(10) GUARDIANSHIP

[**PART THREE is optional.** This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.]

[State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.]

(A)_____ (Initials) I nominate the person serving as my health care agent under PART ONE to serve as my guardian.

OR

(B)_____ (Initials) I nominate the following person to serve as my guardian:

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

PART FOUR: EFFECTIVENESS AND SIGNATURES

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

_____ This advance directive for health care will become effective on or upon _____ and will terminate on or upon_____.

[You must sign and date or acknowledge signing and dating this form in the presence of two witnesses. Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.

A witness:

- Cannot be a person who was selected to be your health care agent or back-up health care agent in PART ONE;
- Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or
- Cannot be a person who is directly involved in your health care.

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).]

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

_____

(Signature of Declarant) (Date)

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

(Signature of First Witness) (Date)

Print Name:_____

Address:_____

_____

(Signature of Second Witness) (Date)

Print Name:_____

Address:_____

[This form does not need to be notarized.]