Advance Care Plan

Tennessee

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

← Print or type your full name here.

Agent

I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below.

Name: _____

Phone number: _____ Relation: _____

Address: _____

You can name someone to make health care decisions for you. This person is called an "agent." If you want to name an agent, fill out this page. If you do not want to name an agent, go to the next page.

Alternate Agent

If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below.

Name: _____

Phone number: _____ Relation: _____

Address: _____

You may name a second ("alternate") agent in case your first agent is unable or unwilling to make health care decisions for you.

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one)

Under "When Effective," mark to show when your agent can begin to make decisions for you. You can let your agent make decisions for you at any time or only when you no longer have "capacity"(when you can no longer make decisions for yourself).

☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.

☐ I do not give such permission (this form applies only when I no longer have capacity).

When you are done, go to the next page if you want to show your wishes for advance care. If not, go to the last page.

Quality of Life

By marking "Yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management.

By marking "No" below, I have indicated conditions I would *not* be willing to live with (that to me would create an unacceptable quality of life).

On this page you can mark the conditions you would be willing to live with and the conditions you would not be willing to live with.

Permanent Unconscious Condition

☐ Yes ☐ No I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

Mark "Yes" if you would be willing to live in a **permanent unconscious condition**.

Mark "No" if you would not.

Permanent Confusion

☐ Yes ☐ No I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

Mark "Yes" if you would be willing to live with **permanent confusion**.

Mark "No" if you would not..

Dependent in All Activities of Daily Living

☐ Yes ☐ No I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.

Mark "Yes" if you would be willing to be **dependent in all activities of daily living**.

Mark "No" if you would not..

End-Stage Illnesses

☐ Yes ☐ No I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Mark "Yes" if you would be willing to live with an **end-stage illness**.

Mark "No"if you would not..

If you marked "No" for any of these conditions, go to the next page.

If you did *not* mark "No" for any of these conditions, go to the last page.

Treatment

If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "No" on the previous page) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "Yes" below, I have indicated treatment I want. By marking "No" below, I have indicated treatment I do *not* want.

On this page you can mark the treatment you would want or not want if your quality of life becomes unacceptable to you. This applies ONLY to the conditions you marked "No" on the previous page.

CPR (Cardiopulmonary Resuscitation)

☐ Yes ☐ No To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.

Mark "Yes" if you would want **CPR** while in a condition you are not willing to live with. Mark "No" if you would not.

Life Support / Other Artificial Support

☐ Yes ☐ No Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.

Mark "Yes" if you would want **life support** while in a condition you are not willing to live with. Mark "No" if you would not.

Treatment of New Conditions

☐ Yes ☐ No Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.

Mark "Yes" if you would want **new conditions treated** while in a condition you are not willing to live with. Mark "No" if you would not.

Tube Feeding / IV Fluids

☐ Yes ☐ No Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Mark "Yes" if you would want **tube feeding or IV fluids** while in a condition you are not willing to live with. Mark "No" if you would not.

Other instructions, such as burial arrangements, hospice care, etc.

_____

You can add more wishes if you want. Attach more pages as needed.

Organ donation

Upon my death, I wish to make the following anatomical gift (mark one):

☐ Any organ/tissue ☐ My entire body ☐ No organ/tissue donation

☐ Only the following organs/tissues: _____

You can offer to donate organs or tissues, but you do not have to. When you are done, go to the last page.

Signature

Your signature must either be witnessed by two competent adults or notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Patient print or type name _____ Patient signature _____ Date _____ Time _____

You must sign this form. You may either sign in front of 2 witnesses or have a notary public notarize your signature. Review the form with your doctor and others to be sure it says what you want it to say. Then sign, date, and write the time here.

Witnesses

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

Witness #1 print or type name _____ Relation _____

Witness #1 signature _____ Date _____ Time _____

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption, and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

Witness #2 print or type name _____ Relation _____

Witness #2 signature _____ Date _____ Time _____

If you sign in front of 2 witnesses, your agent cannot be one of your witnesses.

At least one of your 2 witnesses cannot be related to you or be your beneficiary (inherit from you).

This document may be notarized instead of witnessed:

STATE OF TENNESSEE, COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ Print name: _____

Notary Public signature _____ Date _____ Time _____

If you do not sign in front of 2 witnesses, you must have a notary public notarize your signature. If you have any questions or concerns about this form, please contact Patient Relations at (615) 322-6154. After you have signed this form, and it has been witnessed or notarized:

- give a copy to your doctor
- put a copy in your files where others can find it
- tell your family and friends what is in it
- give a copy to your agent if you have one.