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MyDirectives®
Universal Advance Digital Directive

It is very important for you to discuss your medical treatment goals and wishes with your healthcare agent, your family, and your medical care providers. Keep in mind that advance medical directives are simply expressions of your medical treatment goals and preferences. There is no guarantee that your medical care providers will follow all of your wishes, but one thing is certain: **If your advance medical directives cannot be quickly located and retrieved in a time of need, then medical care providers, your family and friends will not be able to take your wishes into consideration when they make critical decisions regarding your treatment.**

Part 1 – Appointment of a Primary Healthcare Agent and Alternate Healthcare Agents

IF THIS PART OF THE uADD™ IS LEFT BLANK, I AM DELIBERATELY DECLINING TO DESIGNATE A HEALTHCARE AGENT AND REQUESTING THAT THE DOCTORS ON DUTY MAKE DECISIONS BASED ON MY GUIDELINES.

I am appointing the person or persons below as my healthcare agent(s) and, if applicable, as my alternate healthcare agent(s), and I am granting to each of them the legal authority to make medical treatment decisions on my behalf and to consult with my physician and others. The power to make medical treatment decisions that I am granting to my healthcare agent(s) is expressly subject to, and limited by, the choices that I have expressed elsewhere in my uADD. If my medical treatment choices are not clear, then subject to any limitations I have placed on my healthcare agent below, I am authorizing and directing my healthcare agent to make decisions in my best interests and based on what is known of my wishes.

The person I choose as my Primary Healthcare Agent is:

Name: _____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____
Address: _____
City: _____ State: _____ ZIP code: _____

If this healthcare agent is unable or unwilling to make medical treatment decisions for me, or if my spouse is designated as my primary healthcare agent and our marriage is annulled, or we are divorced or legally separated, **then my next choice for a healthcare agent is:**

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First Alternate Healthcare Agent

Name: _____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____
Address: _____
City: _____ State: _____ ZIP code: _____

If this alternate healthcare agent is unable or unwilling to make medical treatment decisions for me, or if my spouse is designated as my first alternate healthcare agent and our marriage is annulled, or we are divorced or legally separated, **then my next choice for a healthcare agent is:**

Second Alternate Healthcare Agent

Name: _____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____
Address: _____
City: _____ State: _____ ZIP code: _____

My Healthcare Agent's General Authority

Subject to my medical treatment choices expressed elsewhere in this uADD™ and applicable law that requires otherwise, I grant to my healthcare agent the power to make all choices and medical treatment decisions for me.

[Here are some specific instructions that expand or limit the powers I have just granted to my healthcare agent(s):_____.]

[If there is time, I would like my healthcare agent, or the doctors on duty if I have not chosen a healthcare agent, to consult with the following people prior to making medical treatment decisions on my behalf:

Name: _____ Relationship: _____
Primary Phone: _____ Secondary Phone: _____
Address: _____
City: _____ State: _____ ZIP code: _____]

Part 2 – Expression of Healthcare Treatment Wishes and Desires

If I cannot express my own wishes for medical treatment, I would like the doctors treating me, as well as my healthcare agent if I have chosen one, to make decisions based as much as possible and appropriate on my instructions below. **[If at some point in the future I am declared incompetent, I DO NOT want to be allowed to override these preferences. I want my doctors to follow the preferences I express in this document.][If at some point in the future I am declared incompetent, I still want to have the power to override the preferences I express in this document.]**

My Advance Care Goals

If I am so sick or seriously injured that I cannot express my own medical treatment preferences, and if I am not expected to live without additional treatment for my illness, disease, condition or injury, then I want my medical care team to know that these are the things that are most important to me:

- ☐☐Being free from pain
- ☐☐Being with my family
- ☐☐Being able to feed, bathe, and take care of myself
- ☐☐Not being a financial burden to my family
- ☐☐Not being a physical burden to my family
- ☐☐Being at peace with my God
- ☐☐Resolving conflicts
- ☐☐Avoiding prolonged dependence on machines
- ☐☐Avoiding prolonged dependence on machines
- ☐☐Avoiding prolonged dependence on artificial or assisted nutrition through tubes
- ☐☐Dying at home
- ☐☐Other things that are very important to me about life and health …

[Here are some thoughts that I would like for my medical care team and my healthcare agent(s) to know about the role that religion, faith or spirituality play in my life:_____.]

[If I am having significant pain or suffering, I would like my doctors to consult a Supportive and Palliative Care Team to help treat my physical, emotional and spiritual discomfort, and to support my family.][Even if I am having significant pain or suffering, I DO NOT want my doctors to consult a Supportive and Palliative Care Team.]

My Preferences in Specific Circumstances

In addition to the general advance care goals provided above, below are specific treatment preferences with respect to certain specific circumstances or situations.

If my health ever deteriorates due to a terminal illness, and my doctors believe I will not be able to interact meaningfully with my family, friends, or surroundings, **[I prefer that they stop all life-sustaining treatments and let me die as gently as possible. I realize that I will not receive life-sustaining treatments including but not limited to breathing machines, blood transfusions, dialysis, heart machines, and IV drugs to keep my heart working. I also realize that medical personnel will not attempt cardiopulmonary resuscitation (CPR), and they will allow me to die naturally.]*[I would like for them to keep trying life-sustaining treatments [for [#][days/weeks/months/years.]][indefinitely.][until my healthcare agent decides it is time to stop and such treatments and let me die gently.]*[I have the following thoughts:]**

[IF MY RESPONSE ABOVE INDICATES THAT I DO NOT WANT LIFE-SUSTAINING TREATMENTS, I EXPRESSLY AUTHORIZE MY ATTENDING PHYSICIAN TO WITHHOLD OR WITHDRAW ARTIFICIAL NUTRITION AND HYDRATION AND INSTRUCT MY HEALTHCARE AGENT (OR, IF I HAVE NOT DESIGNATED A HEALTHCARE AGENT, MY DEFAULT SURROGATE), MY FAMILY AND THE DOCTORS AND NURSES WHO ARE TAKING CARE OF ME TO RESPECT THIS REQUEST.][EVEN IF MY RESPONSE ABOVE INDICATES THAT I DO NOT WANT LIFE-SUSTAINING TREATMENTS, I DO NOT AUTHORIZE MY ATTENDING PHYSICIAN TO WITHHOLD OR WITHDRAW ARTIFICIAL NUTRITION AND HYDRATION. I WANT ARTIFICIAL NUTRITION AND HYDRATION, AND I HEREBY INSTRUCT MY HEALTHCARE AGENT (OR, IF I HAVE NOT DESIGNATED A HEALTHCARE AGENT, MY DEFAULT SURROGATE), MY FAMILY AND THE DOCTORS AND NURSES WHO ARE TAKING CARE OF ME TO RESPECT THIS REQUEST.]

If I have a severe, irreversible brain injury or illness and can't dress, feed, or bathe myself, or communicate my medical wishes, but doctors can keep me alive in this condition for a long period of time, **[I prefer that they stop all life-sustaining treatments and let me die as gently as possible. I realize that I will not receive life-sustaining treatments including but not limited to breathing machines, blood transfusions, dialysis, heart machines, and IV drugs to keep my heart working. I also realize that medical personnel will not attempt cardiopulmonary resuscitation (CPR), and they will allow me to die naturally.]*[I would like for them to keep trying life-sustaining treatments [for [#][days/weeks/months/years.]][indefinitely.][until my healthcare agent decides it is time to stop and such treatments and let me die gently.]*[I have the following thoughts:]**

[IF MY RESPONSE ABOVE INDICATES THAT I DO NOT WANT LIFE-SUSTAINING TREATMENTS, I EXPRESSLY AUTHORIZE MY ATTENDING PHYSICIAN TO WITHHOLD OR WITHDRAW ARTIFICIAL NUTRITION AND HYDRATION AND INSTRUCT MY HEALTHCARE AGENT (OR, IF I HAVE NOT DESIGNATED A HEALTHCARE AGENT, MY DEFAULT SURROGATE), MY FAMILY AND THE DOCTORS AND NURSES WHO ARE TAKING CARE OF ME TO RESPECT THIS REQUEST.][EVEN IF MY

RESPONSE ABOVE INDICATES THAT I DO NOT WANT LIFE-SUSTAINING TREATMENTS, I DO NOT AUTHORIZE MY ATTENDING PHYSICIAN TO WITHHOLD OR WITHDRAW ARTIFICIAL NUTRITION AND HYDRATION. I WANT ARTIFICIAL NUTRITION AND HYDRATION, AND I HEREBY INSTRUCT MY HEALTHCARE AGENT (OR, IF I HAVE NOT DESIGNATED A HEALTHCARE AGENT, MY DEFAULT SURROGATE), MY FAMILY AND THE DOCTORS AND NURSES WHO ARE TAKING CARE OF ME TO RESPECT THIS REQUEST.]

Although I understand that, depending on the situation and circumstances, medical personnel may not be able to follow my wishes, here are my general thoughts on cardiopulmonary resuscitation (CPR):

[I want CPR attempted unless my doctors say I have a terminal illness or a severe, irreversible brain injury, OR I have little chance of long-term survival if my heart or breathing stop, and an attempt to resuscitate me would cause me significant suffering, OR it simply will not work in my condition.]

[I do not want CPR attempted.]

[I want my healthcare agent to decide for me.]

[I want CPR attempted if my heart or breathing stops.]

[*Insert text from box that opens if user clicks on button "I have additional thoughts on this ..."*]

Other Instructions

If it were possible to choose, here is where I would like spend my final days:

- ☐ At home. **[I would like to receive hospice care at home if possible.]**
- ☐ In the hospital. **[I would like to have a consultation with a Supportive and Palliative Care team, if possible.]**
- ☐ In a hospice facility.
- ☐ I'm not sure.

[Here are some additional thoughts that I would like for my medical care team and my healthcare agent(s) to know about where I'd like to spend my final days if I could choose:____.]

I understand that, in certain jurisdictions, if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, medical treatment providers may refuse to follow my directives and provide life-sustaining treatment including artificially administered nutrition and hydration, as well as CPR and other resuscitation measures. Unless I have stated otherwise somewhere else in this uADD, I understand that my healthcare agent may reconsider my medical

treatment choices expressed above in light of my other instructions contained elsewhere in this uADD or new medical information.

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Part 3 – Decisions on Organ Donation and Autopsy

Consent to Donate

☐☐I consent to donate all organs and tissues.

☐☐I consent to donate the following organs and tissues:_____

☐☐I want to donate my entire body.

☐☐I don't want to donate my organs.

☐☐I'd like my healthcare agent to decide that after I die.

☐☐I'm not sure.

[Here are some additional thoughts that I would like for my medical care team and my healthcare agent(s) to know about organ donation:_____.]

Autopsy

☐☐I want an autopsy if my doctor thinks it will help others.

☐☐I want an autopsy only if there are questions about my death.

☐☐I don't want an autopsy.

☐☐I want the person who's designated by law to make this decision after I die.

☐☐I'm not sure.

[Here are some additional thoughts that I would like for my medical care team and my healthcare agent(s) to know about autopsy:_____.]

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Part 4 – My Thoughts

MyDirectives® offers people a list of optional questions that can be answered by typing text in a text box or by uploading a video or audio file for each question. Only those questions answered by **[First Name/Last Name]** appear here. For a complete list of questions in My Thoughts, please visit www.MyDirectives.com.

In case I'm being cared for by a person(s) who doesn't know me very well, I'd like my following thoughts to be known.

My Likes/Joys: Here are some examples of the things that I would like to have near me, music that I'd like to hear, and other details of my care that would help to keep me happy and relaxed: _____.

My Dislikes/Fears: Here is a list of things that I would like to avoid if at all possible, people that I don't wish to see, and concerns I have about particular family members, pets, and so on:_____ _____.

How to Care for Me: If I become incapacitated and cannot express myself, here is what I would like to tell my healthcare agent, family and friends about how I would like for them to care for me: _____.

My Religion: If I appear to be approaching the end of my life, here are some things that I would like for my caregivers to know about my faith and my religion. **[Please attempt to notify someone from the _____ religion at the following phone number, if I have included one.]** In addition, if I appear to be approaching the end of my life, I would like to have the following ceremonies or other care in order to make me more comfortable:_____.

My Unfinished Business: If it appears that I am approaching the end of my life, and I cannot communicate with persons around me, I would want my doctors and nurses, my family, and my friends to know about some unfinished business that I need to address:_____.

If I Were to Pass Away: Here are my thoughts on funeral or burial plans:_____.

Laughter: These are some of my fondest memories from life that have always brought a smile to my face or made me laugh:_____.

Messages to People Who Matter to Me: If I cannot communicate with persons around me, I want my healthcare agent, my family, and my friends to know the following:_____.

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Part 5 – Making the uADD™ Legal

I am emotionally and mentally competent to make this uADD. I understand the purpose and effect of this uADD, I agree with everything that is written in this uADD, and I have made this uADD knowingly, willingly and after careful deliberation.

_____ _____

Signature (or my signature signed by the person named below) Date

I cannot sign my name, so I have asked the person indicated below to sign this uADD™ for me.

_____

Signature of the person who I asked to sign this uADD™ for me.

_____

Printed name of the person who I asked to sign this uADD™ for me.

Statement of Witnesses

I declare that the person who signed this uADD, or who asked another to sign this uADD on his/her behalf, is the individual identified in the document, and he/she did so in my presence or otherwise provided satisfactory proof to me of his/her identity. I believe him/her to be of sound mind and at least 18 years of age. I personally witnessed him/her sign this document or ask the person indicated to do so, or I received proof of his/her identity that I believe is adequate, and I believe that he/she did so voluntarily. By signing this document as a witness, I certify that I am:

- At least 18 years of age.
- Not related to the person signing this document by blood, marriage or adoption.
- Not a healthcare agent appointed by the person signing this document.
- Not directly financially responsible for that person's healthcare.
- Not a healthcare provider directly serving the person at this time.
- Not an employee (other than a social worker or chaplain), officer, director, or partner of a healthcare provider (or any parent organization of such healthcare provider) directly serving the person at this time.
- Not aware that I am entitled to or have a claim against the person's estate.

Witness number 1:

_____ _____

Signature Date

_____

Print Name Email Address

_____

Address

Witness number 2:

Signature _____ Date _____

Print Name _____ Email Address _____

Address _____

Instructions for Notarization:

Residents of certain jurisdictions may have the uADD signed by a notary public registered in their jurisdiction instead of having two witnesses sign the uADD.

Notary Public

On _____ (date), _____ (name) acknowledged in my presence or by sufficient electronic means his/her signature on this uADD or acknowledged that he/she authorized the person signing this uADD to sign on his/her behalf. I am not named as a healthcare agent or alternate healthcare agent in this document.

(Notary Stamp)

_____
Signature of Notary

_____
Email Address

My commission
expires on:_____