CareMEDICA Primary Care
WeightMEDICA Medical Weight Loss
LaserMEDICA Dermacenters USA

ADVANCE DIRECTIVES OF

_____

To Any Physician Who Is Treating Me, this document contains the following:

1. My Appointment of A Health Care Representative
2. My Living Will or Health Care Instructions
3. My Document of Anatomical Gift
4. The Designation of My Conservator Of The Person For My Future Incapacity

As my physician, you may rely on these health care instructions and decisions made by my health care representative or conservator of my person, if I am unable to make a decision for myself.

☐ I choose not to appoint a health care representative. (Initials) _____

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint _____ to be my health care representative.

If my attending physician determines that I am unable 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 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 or mental condition and the decision to provide, withhold or withdraw life support systems, except as otherwise provided by law which excludes for example psychosurgery or shock therapy.

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.

If _____ is unwilling or unable to serve, I appoint _____ to be my alternative health care representative.

I further instruct that as required by law my attending physician disclose to my health care representative protected health information regarding my ability to understand and appreciate the nature and consequences of health care decisions and to reach and communicate an informed decision regarding treatment at the representative's request made at anytime after I sign this form.

☐ I choose not to provide Health Care Instructions. (Initials) _____

LIVING WILL or HEALTH CARE INSTRUCTIONS

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 statement of my wishes.

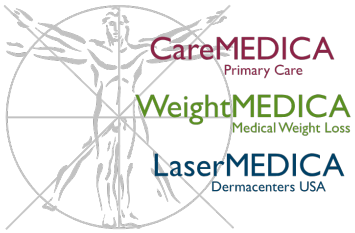
I, _____ the author of this document, request that, if my condition is deemed terminal or if I am **determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems.**

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.

Specific Instructions

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

Treatment	Provide	Withhold
Cardiopulmonary Resuscitation	☐	☐
Artificial Respiration (including a respirator)	☐	☐
Artificial means of providing nutrition and hydration	☐	☐
Other treatment: _____	☐	☐



OTHER SPECIFIC REQUESTS

I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

DOCUMENT OF ANATOMICAL GIFT

☐ I make no anatomical gift at this time. Initials: _____

☐ I make an anatomical gift, if medically acceptable, to take effect upon my death. Initials: _____

I give (check one):

☐ Any needed organs or parts ☐ Only the following organs or parts: _____

To be donated for (check one):

☐ Any purpose stated in subsection (a) of section 19a-279f of the general statutes

☐ These limited purposes: _____

DESIGNATION OF A CONSERVATOR OF THE PERSON

☐ I choose not to designate a person to be appointed as my conservator. Initials: _____

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

If this person is unwilling or unable to serve, I designate _____

No bond shall be required of either of them in any jurisdiction.

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

Signature: _____ Date: _____

WITNESSES' STATEMENTS

This document was signed in our presence by the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

Witness

Signature: _____

Printed name: _____

Street address: _____

City, State and ZIP: _____

Witness

Signature: _____

Printed name: _____

Street address: _____

City, State and ZIP: _____