Honoring Choices® FLORIDA

I CHOOSE *peace of mind.*

Take time to plan ahead now so future health care challenges don't create so many difficult questions and unnecessary worry. ***Peace of mind*** *comes when you have a conversation about your goals, beliefs and experiences and make your wishes known.*

Advance care planning document and instructions are enclosed for:

(Please print your full name) _____

To request additional copies of this booklet for loved ones, or to schedule time with a facilitator, call **904.407.7024** or visit **HonoringChoicesFL.com**.

Honoring Choices®
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Thank you for choosing Honoring Choices® Florida.

Planning ahead for your future health care needs is one of the most caring things you can do for yourself and your loved ones. Tell your family members and health providers the kind of care you want, before a serious illness or injury. When you do, your wishes can be honored, even if you can't share them on your own. This document will help you do that.

What is advance care planning?

Advance care planning is a process of thinking about, discussing and communicating future medical choices should you experience a sudden illness or injury, or a chronic or life-limiting illness. It's more than just the document you complete. Think of it as the end-result of an important process that contains your wishes: your advance care plan.

Some things you can do as part of advance care planning include:

- Learn more about your health care treatment options
- Clarify your health care goals
- Weigh your options about what kind of care and treatment you want or don't want
- Decide whether you want to appoint someone to speak on your behalf, if you are unable to make your own decisions
- Decide whether you want to complete an advance care planning document and put your wishes in writing
- Communicate your wishes and share documents with family, friends, clergy, other advisers, physicians and other health care professionals

What types of medical choices can I consider during advance care planning?

One of the most important choices you can make is to identify the person you would want to speak on your behalf and make decisions for you if you are unable to do so. This is your "surrogate." You also can decide if you do or do not want extraordinary measures to prolong your life, such as cardiopulmonary resuscitation (CPR), renal dialysis, artificial ventilation (respirator), artificial nutrition and hydration (tube feeding), blood transfusions and other measures.

Who should I include in the advance care planning process?

People who participate in advance care planning may include the person chosen to be your health care surrogate, family members and others important to you, and your doctor. These people also should understand what is in your plan, and know when you make changes to your plan and what they are.

Who should do advance care planning and have a plan?

All adults ages 18 and older should have these important conversations with loved ones and create a plan. It's best to do these things when you're healthy, and well before medical procedures or other activities that may put your health at risk.

What is Honoring Choices Florida?

Honoring Choices Florida is a comprehensive, community-based advance care planning program available at no cost to Florida residents ages 18 and up. The goal of this program is to work together as a community to change the standard of care people receive, by helping them choose the care they want, put their wishes in writing and ensure others follow their wishes.

Community Hospice of Northeast Florida created Honoring Choices Florida in 2013 in partnership with local hospitals. It is modeled after an evidence-based advance care planning program called Respecting Choices®. Community Hospice serves as the program's convener, coordinator and catalyst. Its role is to unite community organizations and health providers to create a standard and process for advance care planning in Northeast Florida.

(continued, inside back cover)

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Health Care Directive

I have created this document with much thought to indicate my treatment choices and personal preferences, if I cannot communicate my wishes or am unable to make my own health care decisions. I have also appointed a health care surrogate to speak for me. My surrogate is able to make medical decisions for me, including the decision to decline treatments that I do not want. Any document created before this is no longer legal or valid.

I understand that I need to complete a separate document if I want my surrogate to have authority to make decisions for me related to mental health treatment, electroshock or psychosurgery, sterilization, pregnancy termination, and/or experimental treatments.

My name: _____ My date of birth: _____

My address: _____

My telephone number: _____ My cell: _____

Part 1: Health Care Surrogate Designation

If I am unable to communicate my wishes and health care decisions, or if my physician has determined that I am not able to make my own health care decisions, I choose those person(s) named on page two of this document to express my wishes and make my health care decisions according to the instructions in this document.

My health care surrogate's authority becomes effective when my physician determines that I am unable to make my own decisions ***unless*** I initial either or both statements below. *(Initial by the statement(s) you would want and draw a line through the statements you would not want.)*

____ I want my health care surrogate's authority to receive my health information to take effect immediately.

____ I want my health care surrogate's authority to make health care decisions for me to take effect immediately. Any decisions I make while I possess capacity shall supersede any instructions or decisions made by my surrogate that are in conflict with those made by me.

I understand that my health care surrogate must be at least 18 years of age, and cannot be a health care provider or employee of a health care provider giving direct care to me unless I am related to that person by blood or marriage, domestic partnership, or adoption.

Barcode:

Patient Label

My primary (main) health care surrogate:

Name: _____ Relationship: _____

Telephone numbers: (Primary) _____ (Secondary) _____

(Additional) _____

Address: _____

If I cancel my primary surrogate's authority, or if my primary surrogate is not willing, able, or reasonably available to make a health care decision for me, I name as my alternate surrogate:

1st Alternate health care surrogate:

Name: _____ Relationship: _____

Telephone numbers: (Primary) _____ (Secondary) _____

(Additional) _____

Address: _____

If I cancel my primary and first alternate surrogate's authority, or if they are not willing, able, or reasonably available to make a health care decision for me, I name as my second alternate surrogate:

2nd alternate health care surrogate:

Name: _____ Relationship: _____

Telephone numbers: (Primary) _____ (Secondary) _____

(Additional) _____

Address: _____

If I have chosen my legal spouse as my primary or alternate surrogate, I want this person to continue as my surrogate after dissolution, annulment or termination of our marriage is in process or has been completed.

Initial One: Yes _____ No _____ NA _____

Part 2: General Authority and Powers of My Health Care Surrogate

My health care surrogate automatically has all the following powers when I am unable to speak for myself or communicate my wishes. If I have identified any additional powers or authority, they are written in comments on page four. I want my health care surrogate to interpret any instruction I have given in this form according to my surrogate's understanding of my wishes, values and beliefs.

A. Give consent for treatments and surgeries necessary to treat my condition.
B. Carry out my wishes by making decisions regarding tube feedings, cardio- pulmonary resuscitation (CPR), IV fluids, breathing machines, and other treatments.
C. Review and release my medical records and personal files as needed for my medical care and/or for application for public or private healthcare insurance benefits.
D. Arrange for my medical care and treatment in any state or location my surrogate thinks is appropriate.
E. Decide which health providers and organizations provide my medical treatment.
F. Decide to make an anatomical gift (organ donation).

Barcode:

Patient Label

Part 3: Living Will and Health Care Instructions

My choices and preferences for my health care are noted in this document. I ask my surrogate to express them and my doctors (and/or health care team) to honor them. I understand that these preferences will apply should I become unable to communicate or make my own choices, if at least one of the following medical conditions are present, and if my physician(s) have determined that there is no reasonable medical probability of my recovery from such condition. *Initial by all of the conditions that would apply and draw a line through all that would not apply:*

_____ I have a **TERMINAL CONDITION** (condition caused by injury, disease or illness from which there is no reasonable medical probability of recovery and which, without treatment, can be expected to cause death),

_____ I have an **END-STAGE CONDITION** (an irreversible condition that is caused by injury, disease or illness which has resulted in progressively severe and permanent deterioration and which, to a reasonable degree of medical probability, treatment of the condition would be ineffective),

_____ I am in a **PERSISTENT VEGETATIVE STATE** (permanent and irreversible condition of unconsciousness in which there is the absence of voluntary action or cognitive behavior of any kind, and an inability to communicate or interact purposefully with the environment).

I understand that there may be situations in which my treatment preferences may not be followed, based on Florida law and/or a provider's mission or policies, and my surrogate or I may request a transfer to another provider.

Treatment Preferences:

Cardiopulmonary Resuscitation (CPR):
Initial by the one statement you would want and draw a line through the two statements that you would not want:

_____ I want CPR attempted unless my physician determines I have an incurable illness or injury and am dying; OR I have no reasonable chance of survival if my heart or breathing stop; OR I have little chance of survival if my heart or breathing stop and the process of resuscitation would cause significant suffering.

_____ I want CPR attempted if my heart or breathing stop under all conditions.

_____ I do not want CPR attempted if my heart or breathing stop, but rather, want to allow a natural death.

Specific Treatment Options:
Initial by the treatment options you would want and draw a line through the treatment options you would not want:

_____ Tube feedings and IV hydration

_____ Antibiotics

_____ Dialysis

_____ Respirator/ventilator (breathing tube)

_____ Other _____

_____

Barcode:

Patient Label

Additional Treatment Options:
Initial one and draw a line through the other:

_____ I have attached treatment preferences for my specific health conditions. These statements describe my specific treatment choices. With any treatment choice, I understand I will continue to receive pain and comfort medicines, as well as foods and fluids by mouth if it is determined to be beneficial.

_____ I have not attached any additional documents related to treatment preferences.

Organ Donation:
Initial one and draw a line through the other:

_____ **I do want** to donate my eyes, tissues and/or organs, if able.
My specific wishes (if any) are:

_____

_____

_____ **I do not want** to donate my eyes, tissues and/or organs.

Comments and Instructions:
Important things to consider: additional duties of surrogate; specific treatment preferences; trial periods for interventions; specialized instructions; religious beliefs, faith practices, or cultural values; and/or general comments.

_____

_____

_____

_____

_____

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Barcode:

Patient Label

Part 4: Legal Authority

I have made this document willingly, I am thinking clearly, and this document expresses my wishes about my future health care decisions:

_____	_____	_____	_____
Signature	Print Name	Date	Time

Witness 1:

_____	_____	_____	_____
Signature of Witness 1	Print Name	Date	Time

_____

Address

Witness 2:

_____	_____	_____	_____
Signature of Witness 2	Print Name	Date	Time

_____

Address

Your health care surrogate(s) cannot serve as a witness to this document. At least one witness must be someone other than your spouse or blood relative.

Barcode:

Patient Label

Next Steps Following Completion of Document

Now that you have completed your health care directive, you should also take the following steps:

Tell the person you named as your health care surrogate, if you haven't already done so. Make sure your surrogate feels able to perform this important job for you in the future.

Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care surrogate is, and what your wishes are.

Make sure your wishes are understood and will be followed by your doctor and other medical providers.

Keep a copy of your health care directive where it can be easily found.

If you go to a hospital or nursing home, take a copy of your health care directive and ask that it be placed in your medical record.

Review your health care wishes every time you have a physical exam or whenever any of the "Five D's" occur:

Decade: when you start each new decade of your life
Death: whenever you experience the death of a loved one
Divorce: when you experience a divorce or other major family change
Diagnosis: when you are diagnosed with a serious health condition
Decline: when you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own

In addition to your health surrogate and alternate health surrogates, please specify where copies of this advance health directive will be stored and with whom:

Doctors

Name: _____ contact info: _____

Name: _____ contact info: _____

Hospital

Name: _____ contact info: _____

Others (such as family members, friends, clergy)

Name: _____ contact info: _____

Name: _____ contact info: _____

Name: _____ contact info: _____

Is the Honoring Choices Florida document legally binding? Who will accept it?

Community Hospice and six Northeast Florida health care systems developed this document in adherence with Florida Statutes. Florida health professionals and health care facilities will accept it. Florida laws are very similar to laws of most states, so your document will comply with the laws of most states.

If you travel extensively or spend time living in another state, ask a social worker at a health care facility in that state to review the document. The social worker can confirm that your plan complies with that state's statutes. There should not be a fee for this review, and you don't need to ask an attorney to review it.

What happens if I have a medical emergency? How will my health care providers know about my advance care plan?

It's important to include your health care surrogate, family members, other people important to you and your doctor in advance care planning. They should know you have completed an advance care plan and know where to find it.

Once you have filled out this document and shared it, complete the wallet card below, remove it at the perforation and keep it with important documents you carry at all times, such as your photo ID or Medicare card.

Honoring Choices® FLORIDA

My name: _____

Date of birth: _____

I have an advance care plan dated: _____

It is on file with:

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

It is important for you to complete the information on both sides of the above wallet card.

What if I need to change something I write here?

It's important to review your advance care plan whenever there is change in decade, death of a loved one, divorce, a new diagnosis or a decline. We call these the "5 Ds." Regardless of the reason you want to change something in your plan, start with a new document. Discuss the change with your doctor, health care surrogate and loved ones, destroy any previous versions of your plan, and give copies of your new plan to your surrogate, family, doctors and hospital. The new plan will take its place.

Can I get help filling this out?

This is what makes Honoring Choices Florida different from previous advance directives you may have seen: getting help is part of the plan! We offer a team of trained facilitators who are experts in guiding these conversations. One of them will meet with you and your family at a time and place convenient for you, to guide you in a conversation about your values, goals and experiences. The facilitator also can help you complete the document if you wish, or update it if something needs to change (see question above).

Best of all, this is available at no cost to you. To schedule time with a facilitator, call **904.407.7024** or visit **HonoringChoicesFL.com**.

Do you have this booklet available in other languages?

Honoring Choices Florida has developed a Spanish-language version of this booklet. Call **904.407.7024** to request your copy or visit **HonoringChoicesFL.com** and click the Resources link to download a copy. As the program expands, it will consider publishing this booklet in other languages.

I have more questions. Where can I get help?

Visit **HonoringChoicesFL.com** and click the FAQ link for a list of frequently asked questions, or call **904.407.7024** to leave a message for our Honoring Choices Florida staff.

Honoring Choices®
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Community Hospice of Northeast Florida
4266 Sunbeam Road
Jacksonville, FL 32257

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An advance care planning initiative led by Community Hospice of Northeast Florida

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HonoringChoicesFL.com

A 2013 review of patient deaths at several Northeast Florida hospitals revealed less than 14 percent of patients had an advance directive in their medical record.

At Honoring Choices Florida, we know that's not good enough.

We've partnered with six area health systems to find a better way. Together, we're helping people all over Northeast Florida have important conversations about their health care wishes.

We're ready to partner with you and your loved ones, too. Let's have a conversation.

It is important for you to complete the information on both sides of this wallet card.

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My healthcare surrogate is:
Name: _____
Address: _____
City: _____ State: _____ ZIP: _____
Phone: _____ (home)
_____ (work)
_____ (cell)

Honoring Choices Florida is a program of Community Hospice of Northeast Florida.