Health Care Proxy Form Instructions

Item (1): Write the name, home address and telephone number of the person you are selecting as your agent.

Item (2): If you want to appoint an alternate agent, write the name, home address and telephone number of the person you are selecting as your alternate agent.

Item (3): Your Health Care Proxy will remain valid indefinitely unless you set an expiration date or condition for its expiration. This section is optional and should be filled in only if you want your Health Care Proxy to expire.

Item (4): If you have special instructions for your agent, write them here. Also, if you wish to limit your agent's authority in any way, you may say so here or discuss them with your health care agent. If you do not state any limitations, your agent will be allowed to make all health care decisions that you could have made, including the decision to consent to or refuse life-sustaining treatment.

If you want to give your agent broad authority, you may do so right on the form. Simply write: ***I have discussed my wishes with my health care agent and alternate and they know my wishes, including those about artificial nutrition and hydration.***

If you wish to make more specific instructions, you could say:

If I become terminally ill, I do/don't want to receive the following types of treatment:

If I am in a coma or have little conscious understanding, with no hope of recovery, then I do/don't want the following types of treatments:

If I have brain damage or a brain disease that makes me unable to recognize people or speak and there is no hope that my condition will improve, I do/don't want the following types of treatments:

I have discussed with my agent my wishes about _____ and I want my agent to make all decisions about these measures.

Examples of medical treatments about which you may wish to give your agent special instructions are listed below (not a complete list):

- Artificial respiration
- Artificial nutrition and hydration (nourishment and water provided by feeding tube)
- Cardiopulmonary resuscitation (CPR)
- Antipsychotic medication
- Electric shock therapy
- Antibiotics
- Surgical procedures
- Dialysis
- Transplantation
- Blood transfusions
- Abortion
- Sterilization

Item (5): You must date and sign this Health Care Proxy form. If you are unable to sign yourself, you may direct someone else to sign in your presence. Be sure to include your address.

Item (6): You may state wishes or instructions about organ and/or tissue donation on this form. A health care agent cannot make a decision about organ and/or tissue donation because the agent's authority ends upon your death. The law does provide for certain individuals in order of priority to consent to an organ and/or tissue donation on your behalf: your spouse, a son or daughter 18 years of age or older, either of your parents, a brother or sister 18 years of age or older, a guardian appointed by a court prior to the donor's death or any other legally authorized person.

Item (7): Two witnesses 18 years of age or older must sign this Health Care Proxy form. The person who is appointed your agent or alternate agent cannot sign as a witness.

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Health Care Proxy Form

Patient Name: _____

Chart #: _____ DOB: ____ / ____ / ____

(1) I,

_____

Patient Name

HEREBY APPOINT

_____

Full Name

_____

Home Address and Telephone Number

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise. This proxy shall take effect only when and if I become unable to make my own health care decisions.

(2) OPTIONAL: ALTERNATE AGENT

If the person I appoint is unable, unwilling or unavailable to act as my health care agent, I hereby appoint

_____

Full Name

_____

Home Address and Telephone Number

as my health care agent to make any and all health care decisions for me, except to the extent that I state otherwise.

(3) UNLESS I REVOKE IT OR STATE AN EXPIRATION DATE OR CIRCUMSTANCES UNDER WHICH IT WILL EXPIRE, THIS PROXY SHALL REMAIN IN EFFECT INDEFINITELY. *(Optional: If you want this proxy to expire, state the date or conditions here.)*

This proxy shall expire (specify date or conditions):

_____

_____

_____

(4) OPTIONAL: I DIRECT MY HEALTH CARE AGENT TO MAKE HEALTH CARE DECISIONS ACCORDING TO MY WISHES AND LIMITATIONS, AS HE OR SHE KNOWS OR AS STATED BELOW. *(If you want to limit your agent's authority to make health care decisions for you or to give specific instructions, you may state your wishes or limitations here.)*

I direct my health care agent to make health care decisions in accordance with the following limitations and/or instructions *(attach additional pages as necessary):*

_____

_____

_____

In order for your agent to make health care decisions for you about artificial nutrition and hydration (nourishment and water provided by feeding tube and intravenous line), your agent must reasonably know your wishes. You can either tell your agent what your wishes are or include them in this section. See instructions for sample language that you could use if you choose to include your wishes on this form, including your wishes about artificial nutrition and hydration.

NEW YORK state department of HEALTH

Health Care Proxy Form *(continued)*

Patient Name: _____

Chart #: _____ DOB: ____ / ____ / ____

(5) YOUR IDENTIFICATION *(please print)*

_____
Full Name

_____
Address

_____
Signature Date

(6) OPTIONAL: ORGAN AND/OR TISSUE DONATION

I hereby make an anatomical gift, to be effective upon my death, of (check any that apply):

❑ Any needed organs and/or tissues

❑ The following organs and/or tissues:

_____

❑ Limitations:

_____

If you do not state your wishes or instructions about organ and/or tissue donation on this form, it will not be taken to mean that you do not wish to make a donation or prevent a person, who is otherwise authorized by law, to consent to a donation on your behalf.

_____
Signature Date

(7) STATEMENT BY WITNESSES *(Witnesses must be 18 years of age or older and cannot be the health care agent or alternate.)*

I declare that the person who signed this document is personally known to me and appears to be of sound mind and acting of his or her own freewill. He or she signed (or asked another to sign for him or her) this document in my presence.

_____
Date

Name of Witness 1

_____
Print

_____
Address

_____
Signature

_____
Date

Name of Witness 2

_____
Print

_____
Address

_____
Signature

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