

GEORGIA Advance Directive Planning for Important Healthcare Decisions

Caring Connections

1731 King St., Suite 100, Alexandria, VA 22314

www.caringinfo.org

800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you could receive healthcare.
2. These materials include:
 - Instructions for preparing your advance directive, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

INTRODUCTION TO YOUR GEORGIA ADVANCE DIRECTIVE FOR HEALTHCARE

This packet contains one legal document, the Georgia Advance Directive for Healthcare, that protects your right to refuse medical treatment you do not want or to request treatment you do want, in the event you lose the ability to make decisions yourself. The form contains three parts, any number of which may be filled out, and a fourth signature page that must be filled out for any of the three preceding parts to be effective.

1. Part One: **Healthcare Agent**. This allows you to choose someone to make healthcare decisions for you when you cannot (or do not want to) make healthcare decisions for yourself. You may also have your healthcare agent make decisions for you after your death with respect to an autopsy, organ donation, body donation, and final disposition of your body.

2. Part Two: **Treatment Preferences**. This part allows you to state your treatment preferences if you are (1) unable to communicate your treatment preferences, and (2) you either have a terminal condition or are in a state of permanent unconsciousness. This part is optional. If you also have a healthcare agent, then your agent is authorized to make all decisions discussed in Part Two, but will be guided by your written Treatment Preferences as well as the other factors listed in section 4 of Part One.

3. Part Three: **Guardianship**. This part allows you to nominate a person to be your guardian should one ever be needed.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

GEORGIA DURABLE POWER OF ATTORNEY FOR HEALTHCARE

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent can be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

No physician or healthcare provider may act as your agent if he or she is directly involved in your healthcare.

You can appoint a second and third person as your alternate agent(s). The alternate will step in if the first person you name as agent is unable, unwilling or unavailable to act for you.

How do I make my Georgia Healthcare Agent legal?

The law requires that you sign your document, or direct another to sign it in your presence and at your express direction, in the presence of two witnesses who must be at least 18 years of age and of sound mind.

Neither witness can be a person who is any of the following: (1) is your healthcare agent; (2) will knowingly inherit anything from you or otherwise gain a financial benefit from your death; or (3) is directly involved in your healthcare.

Not more than one witness can be an employee, agent, or medical staff member of the healthcare facility in which you are receiving healthcare.

Note: You do not need to notarize your Georgia Advance Directive for Healthcare.

Should I add personal instructions to my Treatment Preferences document?

You can add personal instructions in section 8, "Additional instructions." For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. You may also want to state your specific preferences regarding pain relief.

Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your healthcare agent (if you have selected a healthcare agent in PART ONE) about following your treatment preferences and what you consider to be an acceptable "quality of life." One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee.

GEORGIA DURABLE POWER OF ATTORNEY FOR HEALTHCARE (CONTINUED)

What if I change my mind?

Revocation

You may revoke your Georgia Advance Directive for Healthcare at any time, regardless of your mental or physical condition, by:

- obliterating, burning, tearing, or otherwise destroying your document,
- signing and dating a written revocation or directing another person to do so (if you are receiving healthcare in a healthcare facility, the revocation must be communicated to your attending physician) , or
- orally revoking your document in the presence of a witness, at least 18 years of age, who must sign and date a written confirmation of your revocation within 30 days (if you are receiving healthcare in a healthcare facility, the revocation must be communicated to your attending physician).

Change in Marital Status

If you get married after completing the form for Power of Attorney for Healthcare and you have not named your spouse as your agent, your marriage automatically revokes the power of your agent. If you have appointed your spouse as your agent and your marriage ends, your agent's power is automatically revoked.

What other important facts should I know?

Pregnancy

If you are a woman and would like your Treatment Preferences regarding withholding or withdrawal of life-sustaining procedures, nourishment, or hydration to be honored even if you are pregnant, you must initial the statement in section 9 of the Advance Directive for healthcare form.

State law requires that before honoring a pregnant patient's Treatment Preferences, the attending physician must first determine whether the fetus is viable. If the fetus is viable, your Treatment Preferences will not be honored, even if you initial section 9.

Guardianship

Part III of your Advance Directive provides space where you can nominate someone to serve as your guardian if there should come a time when you need a court-appointed guardian. Unless a court specifies otherwise, your guardian has no power to make any personal or healthcare decisions granted to your agent under your Advance Directive for Healthcare.

NOTICE: The purpose of this Healthcare Agent form is to give the person you designate (your agent) broad powers to make healthcare decisions for you. Such decisions include the power to require, consent to, or withdraw any type of personal care or medical treatment for any physical or mental condition and to admit you to or discharge you from any hospital, home, or other institution. Such decisions do NOT include psychosurgery, sterilization, or involuntary hospitalization or treatment covered by Title 37 of the Official Code of Georgia Annotated.

The Healthcare Agent form does NOT impose a duty on your agent to exercise granted powers or to assume responsibility for your healthcare. However, when your agent does exercise granted powers, your agent will have to use due care to act for your benefit and in accordance with the terms of the Advance Directive for Healthcare.

Your healthcare agent may exercise the granted powers throughout your lifetime, even after you become disabled, incapacitated, or incompetent, until any of the following occur: (1) you expressly limit the duration of the granted powers in the Healthcare Agent form below; (2) you revoke the granted powers; or (3) a court acting on your behalf terminates the agent, which it may do if it finds your agent is acting improperly.

IF THERE IS ANYTHING ABOUT THIS FORM THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

INSTRUCTIONS

PRINT YOUR NAME
AND BIRTH DATE

By: _____
(Print Name)

Date of Birth: _____
(Month/Day/Year)

PART ONE: HEALTH CARE AGENT

(1) HEALTH CARE AGENT

I select the following person as my health care agent to make health care decisions for me:

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

(2) BACK-UP HEALTH CARE AGENT

[This section is optional. PART ONE will be effective even if this section is left blank.]

If my health care agent cannot be contacted in a reasonable time period and cannot be located with reasonable efforts or for any reason my health care agent is unavailable or unable or unwilling to act as my health care agent, then I select the following, each to act successively in the order named, as my back-up health care agent(s):

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

Name: _____

Address: _____

Telephone Numbers: _____
(Home, Work, and Mobile)

PRINT THE NAME
AND ADDRESS OF
YOUR AGENT

PRINT NAME AND
ADDRESS OF
YOUR ALTERNATE
AGENTS

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(3) GENERAL POWERS OF HEALTH CARE AGENT

My health care agent will make health care decisions for me when I am unable to make my health care decisions or I choose to have my health care agent make my health care decisions. My health care agent will have the same authority to make any health care decision that I could make.

My health care agent's authority includes, for example, the power to:

- Admit me to or discharge me from any hospital, skilled nursing facility, hospice, or other health care facility or service;
- Request, consent to, withhold, or withdraw any type of health care; and
- Contract for any health care facility or service for me, and to obligate me to pay for these services (and my health care agent will not be financially liable for any services or care contracted for me or on my behalf).

My health care agent will be my personal representative for all purposes of federal or state law related to privacy of medical records (including the Health Insurance Portability and Accountability Act of 1996) and will have the same access to my medical records that I have and can disclose the contents of my medical records to others for my ongoing health care.

My health care agent may accompany me in an ambulance or air ambulance if in the opinion of the ambulance personnel protocol permits a passenger and my health care agent may visit or consult with me in person while I am in a hospital, skilled nursing facility, hospice, or other health care facility or service if its protocol permits visitation.

My health care agent may present a copy of this advance directive for health care in lieu of the original and the copy will have the same meaning and effect as the original.

- I understand that under Georgia law:
 - My health care agent may refuse to act as my health care agent;
- A court can take away the powers of my health care agent if it finds that my health care agent is not acting properly; and
- My health care agent does not have the power to make health care decisions for me regarding psychosurgery, sterilization, or treatment or involuntary hospitalization for mental or emotional illness, mental retardation, or addictive disease.

(4) GUIDANCE FOR HEALTH CARE AGENT

When making health care decisions for me, my health care agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in PART TWO (if I have filled out PART TWO), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

(5) POWERS OF HEALTH CARE AGENT AFTER DEATH

(A) AUTOPSY

My health care agent will have the power to authorize an autopsy of my body unless I have limited my health care agent's power by initialing below.

_____ (Initials) My health care agent will not have the power to authorize an autopsy of my body (unless an autopsy is required by law).

(B) ORGAN DONATION AND DONATION OF BODY

My health care agent will have the power to make a disposition of any part or all of my body for medical purposes pursuant to the Georgia Anatomical Gift Act, unless I have limited my health care agent's power by initialing below.

[Initial each statement that you want to apply.]

_____ (Initials) My health care agent will not have the power to make a disposition of my body for use in a medical study program.

_____ (Initials) My health care agent will not have the power to donate any of my organs.

(C) FINAL DISPOSITION OF BODY

My health care agent will have the power to make decisions about the final disposition of my body unless I have initialed below.

_____ (Initials) I want the following person to make decisions about the final disposition of my body:

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

I wish for my body to be:

_____ (Initials) Buried

OR

_____ (Initials) Cremated

INITIAL STATEMENT
THAT YOU WANT
TO APPLY

INITIAL THE ONE
STATEMENT THAT
REFLECTS YOUR
WISH

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PART TWO: TREATMENT PREFERENCES

[PART TWO will be effective only if you are unable to communicate your treatment preferences after reasonable and appropriate efforts have been made to communicate with you about your treatment preferences. PART TWO will be effective even if PART ONE is not completed. If you have not selected a health care agent in PART ONE, or if your health care agent is not available, then PART TWO will provide your physician and other health care providers with your treatment preferences. If you have selected a health care agent in PART ONE, then your health care agent will have the authority to make all health care decisions for you regarding matters covered by PART TWO. Your health care agent will be guided by your treatment preferences and other factors described in Section (4) of PART ONE.]

(6) CONDITIONS

PART TWO will be effective if I am in any of the following conditions:

[Initial each condition in which you want PART TWO to be effective.]

_____ (Initials) A terminal condition, which means I have an incurable or irreversible condition that will result in my death in a relatively short period of time.

_____ (Initials) A state of permanent unconsciousness, which means I am in an incurable or irreversible condition in which I am not aware of myself or my environment and I show no behavioral response to my environment.

My condition will be certified in writing after personal examination by my attending physician and a second physician in accordance with currently accepted medical standards.

(7) TREATMENT PREFERENCES

[State your treatment preference by initialing (A), (B), or (C). If you choose (C), state your additional treatment preferences by initialing one or more of the statements following (C). You may provide additional instructions about your treatment preferences in the next section. You will be provided with comfort care, including pain relief, but you may also want to state your specific preferences regarding pain relief in the next section.]

If I am in any condition that I initialed in Section (6) above and I can no longer communicate my treatment preferences after reasonable and appropriate efforts have been made to communicate with me about my treatment preferences, then:

INITIAL THE
STATEMENTS THAT
REFLECTS YOUR
WISH

INITIAL ONE
STATEMENT THAT
REFLECTS YOUR
WISH

(A) _____ (Initials) Try to extend my life for as long as possible, using all medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive. If I am unable to take nutrition or fluids by mouth, then I want to receive nutrition or fluids by tube or other medical means.

OR

(B) _____ (Initials) Allow my natural death to occur. I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me. I do not want to receive nutrition or fluids by tube or other medical means except as needed to provide pain medication.

OR

(C) _____ (Initials) I do not want any medications, machines, or other medical procedures that in reasonable medical judgment could keep me alive but cannot cure me, except as follows:

[Initial each statement that you want to apply to option (C).]

_____ (Initials) If I am unable to take nutrition by mouth, I want to receive nutrition by tube or other medical means.

_____ (Initials) If I am unable to take fluids by mouth, I want to receive fluids by tube or other medical means.

_____ (Initials) If I need assistance to breathe, I want to have a ventilator used.

_____ (Initials) If my heart or pulse has stopped, I want to have cardiopulmonary resuscitation (CPR) used.

(8) ADDITIONAL STATEMENTS

[This section is optional. PART TWO will be effective even if this section is left blank. This section allows you to state additional treatment preferences, to provide additional guidance to your health care agent (if you have selected a health care agent in PART ONE), or to provide information about your personal and religious values about your medical treatment. For example, you may want to state your treatment preferences regarding medications to fight infection, surgery, amputation, blood transfusion, or kidney dialysis. Understanding that you cannot foresee everything that could happen to you after you can no longer communicate your treatment preferences, you may want to provide guidance to your health care agent (if you have selected a health care agent in PART ONE) about following your treatment preferences. You may want to state your specific preferences regarding pain relief.]

OPTIONAL SECTION

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(9) IN CASE OF PREGNANCY

[PART TWO will be effective even if this section is left blank.]

I understand that under Georgia law, PART TWO generally will have no force and effect if I am pregnant unless the fetus is not viable and I indicate by initialing below that I want PART TWO to be carried out.

INITIAL

_____ (Initials) I want PART TWO to be carried out if my fetus is not viable.

PART THREE: GUARDIANSHIP

(10) GUARDIANSHIP

[PART THREE is optional. This advance directive for health care will be effective even if PART THREE is left blank. If you wish to nominate a person to be your guardian in the event a court decides that a guardian should be appointed, complete PART THREE. A court will appoint a guardian for you if the court finds that you are not able to make significant responsible decisions for yourself regarding your personal support, safety, or welfare. A court will appoint the person nominated by you if the court finds that the appointment will serve your best interest and welfare. If you have selected a health care agent in PART ONE, you may (but are not required to) nominate the same person to be your guardian. If your health care agent and guardian are not the same person, your health care agent will have priority over your guardian in making your health care decisions, unless a court determines otherwise.]

[State your preference by initialing (A) or (B). Choose (A) only if you have also completed PART ONE.]

(A) _____ (Initials) I nominate the person serving as my health care agent under PART ONE to serve as my guardian.

OR

(B) _____ (Initials) I nominate the following person to serve as my guardian:

Name: _____

Address: _____

Telephone Numbers: _____

(Home, Work, and Mobile)

PART FOUR: EFFECTIVENESS AND SIGNATURES

This advance directive for health care will become effective only if I am unable or choose not to make or communicate my own health care decisions.

This form revokes any advance directive for health care, durable power of attorney for health care, health care proxy, or living will that I have completed before this date.

Unless I have initialed below and have provided alternative future dates or events, this advance directive for health care will become effective at the time I sign it and will remain effective until my death (and after my death to the extent authorized in Section (5) of PART ONE).

_____ (Initials) This advance directive for health care will become effective on or upon _____ and will terminate on or upon _____.

[You must sign and date or acknowledge signing and dating this form in the presence of two witnesses. Both witnesses must be of sound mind and must be at least 18 years of age, but the witnesses do not have to be together or present with you when you sign this form.]

A witness:

- *Cannot be a person who was selected to be your health care agent or back-up health care agent in PART ONE;*
- *Cannot be a person who will knowingly inherit anything from you or otherwise knowingly gain a financial benefit from your death; or*
- *Cannot be a person who is directly involved in your health care.*

Only one of the witnesses may be an employee, agent, or medical staff member of the hospital, skilled nursing facility, hospice, or other health care facility in which you are receiving health care (but this witness cannot be directly involved in your health care).]

By signing below, I state that I am emotionally and mentally capable of making this advance directive for health care and that I understand its purpose and effect.

(Signature of Declarant) (Date)

INITIAL

SIGN AND DATE

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WITNESS

The declarant signed this form in my presence or acknowledged signing this form to me. Based upon my personal observation, the declarant appeared to be emotionally and mentally capable of making this advance directive for health care and signed this form willingly and voluntarily.

SIGN AND DATE

(Signature of witness) (Date)

Print Name: _____

Address: _____

(Signature of witness) (Date)

Print Name: _____

Address: _____

[This form does not need to be notarized.]

You Have Filled Out Your Advance Directive, Now What?

1. Your Georgia Advance Directive for Healthcare is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your agent and alternate agents, doctor(s), family, close friends, clergy, and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your agent and alternates, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.
5. Remember, you can always revoke any of your Georgia documents.
6. Be aware that your Georgia documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**