

TENNESSEE
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections

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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:

Learn about options for end-of-life services and care

Implement plans to ensure wishes are honored

Voice decisions to family, friends and healthcare providers

Engage 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 may 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 TENNESSEE ADVANCE DIRECTIVE

This packet contains two legal documents that protect 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:

1. The Appointment of Healthcare Agent lets you name someone to make decisions about your medical care—including decisions about life support—if you can no longer speak for yourself. The Appointment of Healthcare Agent is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

2. The Advance Care Plan lets you state your wishes about medical care in the event that you become terminally ill, permanently unconscious or enter a persistent vegetative state and can no longer make your own medical decisions. The Advance Care Plan becomes effective if your death would occur regardless of the use of life-sustaining medical care.

Tennessee has combined both of these documents so that you may appoint a healthcare agent and complete an advance care plan using the same form.

Note: These documents will be legally binding only if the person completing them is a competent adult or an emancipated minor.

COMPLETING YOUR TENNESSEE APPOINTMENT OF HEALTHCARE AGENT

Whom should I appoint as my healthcare agent?

Your healthcare agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your healthcare agent can be a family member or a close friend whom you trust to make serious decisions. The person you name as your healthcare agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (A healthcare agent may also be called an “attorney-in-fact” or “proxy.”)

- The person you appoint as your healthcare agent should not be your doctor or another person who is likely to be your future healthcare provider.

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

How do I make my Tennessee Appointment of Healthcare Agent legal?

In order to make your Appointment of Healthcare Agent legally binding, you and two witnesses must sign the document. Your witnesses must sign the document to show that they are qualified witnesses. You may have the Appointment of Healthcare Agent notarized instead.

These witnesses **cannot** be: the person you name as your agent, and at least one of your witnesses must be a person who is not related to you (by blood, marriage or adoption) and who will not inherit from you under any existing will or codicil or by operation of law.

Should I add personal instructions to my Appointment of Healthcare Agent?

It is advisable for you to talk with your healthcare agent about your future medical care and describe what you consider to be an acceptable “quality of life.” If you want to record your wishes about specific treatments or conditions, you should use your Advance Care Plan.

What if I change my mind?

You may revoke your Appointment of Healthcare Agent at any time by a signed writing or by personally informing your healthcare provider.

If you have appointed your spouse as your healthcare agent, and your marriage is dissolved or annulled, or if you obtain a decree of divorce or legal separation, your agent’s authority is automatically revoked unless otherwise specified in the decree or advance directive.

COMPLETING YOUR TENNESSEE ADVANCE CARE PLAN

How do I make my Tennessee Advance Care Plan legal?

In order to make your Advance Care Plan legally binding, you and two witnesses must sign the document. Your witnesses must sign the document to show that they are qualified witnesses. Alternatively, you may have the document notarized after you sign it.

These witnesses **cannot be** the person you name as your agent, and at least one of your witnesses must be a person who is not related to you (by blood, marriage or adoption) and who will not inherit from you under any existing will or codicil or by operation of law.

Can I add personal instructions to my Advance Care Plan?

Yes. You can add personal instructions in the part of the document called "Other instructions." This is important because it is unclear when you would be considered "terminal" under Tennessee law.

You may also want to refuse specific treatments by a statement such as, "I especially do not want cardiopulmonary resuscitation, a respirator, or antibiotics," or to emphasize pain control by adding instructions such as, "I want to receive as much pain medication as necessary to ensure my comfort, even if it may hasten my death."

If you wish to refuse artificial nutrition and hydration, you must check the box marked "No" on page 1 of your Advance Care Plan.

If you have appointed an attorney-in-fact, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Advance Care Plan are to be decided by my agent."

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor for more information.

What if I change my mind?

- You may revoke your Advance Care Plan at any time and in any manner that communicates your intent to revoke.

What other important facts should I know?

You may use your Advance Care Plan to indicate that you want to donate your organs for transplantation by checking the appropriate space on page 2 of your Advance Care Plan.

TENNESSEE ADVANCE CARE PLAN

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name: _____ Phone #: _____ Relation: _____

Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: _____ Phone #: _____ Relation: _____

Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (**you can check as many of these items as you want**):

- Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- Permanent Confusion:** I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. **Checking “yes” means I WANT the treatment. Checking “no” means I DO NOT want the treatment.**

<input type="checkbox"/>	<input type="checkbox"/>	<u>CPR (Cardiopulmonary Resuscitation):</u> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<u>Life Support / Other Artificial Support:</u> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<u>Treatment of New Conditions:</u> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	<u>Tube feeding/IV fluids:</u> Use of tubes to deliver food and water to patient’s stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.
Yes	No	

Other instructions, such as burial arrangements, hospice care, etc.:

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

- Any organ/tissue My entire body Only the following organs/tissues:

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: _____
(Patient)

DATE: _____

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF TENNESSEE

COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

Signature of Notary Public

What to do with this advance directive?

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

APPOINTMENT OF HEALTH CARE AGENT
(Tennessee)

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:

Alternate:

Name

Name

Address

Address

City State Zip Code

City State Zip Code

() _____
Area Code Home Phone Number

() _____
Area Code Home Phone Number

() _____
Area Code Work Phone Number

() _____
Area Code Work Phone Number

() _____
Area Code Mobile Phone Number

() _____
Area Code Mobile Phone Number

Patient's name (please print or type) Date

Signature of patient (must be at least 18 or emancipated minor)

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

<p style="text-align: center;">Physician Orders for Scope of Treatment (POST)</p> <p>This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, <u>first</u> follow these orders, <u>then</u> contact physician.</p>	<p>Patient's Last Name</p> <hr/> <p>First Name/Middle Initial</p> <hr/> <p>Date of Birth</p>
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<p>Section A</p> <p><i>Check One Box Only</i></p>	<p>CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse <u>and/or</u> is not breathing.</p> <p><input type="checkbox"/> Resuscitate (CPR) <input type="checkbox"/> Do Not Attempt Resuscitate (DNR/no CPR)</p> <p>When not in cardiopulmonary arrest, follow orders in B, C, and D.</p>
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<p>Section B</p> <p><i>Check One Box Only</i></p>	<p>MEDICAL INTERVENTIONS. Patient has pulse <u>and/or</u> is breathing.</p> <p><input type="checkbox"/> Comfort Measures Treat with dignity and respect. Keep clean, warm, and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital for life-sustaining treatment. Transfer <u>only</u> if comfort needs cannot be met in current location.</p> <p><input type="checkbox"/> Limited Additional Interventions Includes care described above. Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation. Transfer to hospital if indicated. Avoid intensive care.</p> <p><input type="checkbox"/> Full Treatment. Includes care above. Use intubation, advanced airway interventions mechanical ventilation, and cardio version as indicated. Transfer to hospital if indicated. Include intensive care.</p> <p><i>Other Instructions:</i> _____</p>
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<p>Section C</p> <p><i>Check One Box Only</i></p>	<p>ANTIBIOTICS – Treatment for new medical conditions:</p> <p><input type="checkbox"/> No Antibiotics</p> <p><input type="checkbox"/> Antibiotics</p> <p><i>Other Instructions:</i> _____</p>
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<p>Section D</p> <p><i>Check One Box Only in Each Column</i></p>	<p>MEDICALLY ADMINISTERED FLUIDS AND NUTRITION. Oral fluids and nutrition must be offered if medically feasible.</p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> No IV fluids (provide other measures to assure comfort)</td> <td><input type="checkbox"/> No feeding tube</td> </tr> <tr> <td><input type="checkbox"/> IV fluids for a defined trial period</td> <td><input type="checkbox"/> Feeding tube for a defined trial period</td> </tr> <tr> <td><input type="checkbox"/> IV fluids long-term if indicated</td> <td><input type="checkbox"/> Feeding tube long-term</td> </tr> </table> <p><i>Other Instructions:</i> _____</p>	<input type="checkbox"/> No IV fluids (provide other measures to assure comfort)	<input type="checkbox"/> No feeding tube	<input type="checkbox"/> IV fluids for a defined trial period	<input type="checkbox"/> Feeding tube for a defined trial period	<input type="checkbox"/> IV fluids long-term if indicated	<input type="checkbox"/> Feeding tube long-term
<input type="checkbox"/> No IV fluids (provide other measures to assure comfort)	<input type="checkbox"/> No feeding tube						
<input type="checkbox"/> IV fluids for a defined trial period	<input type="checkbox"/> Feeding tube for a defined trial period						
<input type="checkbox"/> IV fluids long-term if indicated	<input type="checkbox"/> Feeding tube long-term						

<p>Section E</p> <p><i>Must be Completed</i></p>	<p>Discussed with:</p> <p><input type="checkbox"/> Patient/Resident</p> <p><input type="checkbox"/> Health care agent</p> <p><input type="checkbox"/> Court-appointed guardian</p> <p><input type="checkbox"/> Health care surrogate</p> <p><input type="checkbox"/> Parent of minor</p> <p><input type="checkbox"/> Other: _____ (Specify)</p>	<p>The Basis for These Orders Is: (Must be completed)</p> <p><input type="checkbox"/> Patient's preferences</p> <p><input type="checkbox"/> Patient's best interest (patient lacks capacity or preferences unknown)</p> <p><input type="checkbox"/> Medical indications</p> <p><input type="checkbox"/> (Other) _____</p>
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Physician Name (Print)	Physician Phone Number	Office Use Only
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	Physician Signature (Mandatory)	Date	
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COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Significant thought has been given to life-sustaining treatment. Preferences have been expressed to a physician and/or health care professional(s). This document reflects those treatment preferences.

(If signed by surrogate, preferences expressed must reflect patient's wishes as best understood by surrogate.)

Signature	Name (print)	Relationship (write "self" if patient)
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Contact Information

Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

POST must be signed by a physician to be valid. Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

- (1) The patient is transferred from one care setting or care level to another, or
- (2) There is a substantial change in the patient's health status, or
- (3) The patient's treatment preferences change.

Draw line through sections A through E and write "VOID" in large letters if POST is replaced or becomes invalid.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

DO NOT ALTER THIS FORM!

You Have Filled Out Your Advance Directive, Now What?

1. Your Tennessee Appointment of Healthcare Agent and Tennessee Advance Care Plan are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents 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 attorney-in-fact and alternate attorney-in-fact, 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 attorney-in-fact and alternate, 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 one or both of your Tennessee documents.
6. Be aware that your Tennessee 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.**