

**Advance directive**

Concerning my medical treatment and care

**My last name is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**My first name is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**My date of birth is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**My place of birth is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**The following persons / institutions will receive a copy of this advance directive:**

**If known, please add contact information**

**1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Explanation**

In an advance directive you record your preferences concerning medical treatment, e.g. concerning artificial feeding or cardiopulmonary resuscitation. The use of an advance directive is intended for situations in which you are no longer able to discuss these kind of preferences with your physician.

In this advance directive you can record which preferences are important to you. You can also appoint a person who is allowed to make decisions concerning your medical treatment in cases you are no longer able to do this yourself. This person is called a *surrogate decision-maker*.

This advance directive only becomes valid when your physician has determined that you are no longer able to make decisions yourself.

This advance directive does not permit your surrogate decision-maker to make decisions on your behalf about finances or about other issues. Before you complete this document, it is important that you first discuss with your intended surrogate decision-maker which decisions are important to you.

In principle, this advance directive always remains valid. To prevent misunderstandings, it is important that you discuss its content regularly, e.g. every year, with your physician. If you change your preferences, you can complete a new advance directive.

**Completion of the advance directive**

The advance directive is divided into four parts.

Part I - *Who makes decisions about my medical treatment when I am no longer able to do this myself.*

In this part you record the name of your surrogate decision-maker(s) to make clear who can make decisions on your behalf if necessary. The surrogate decision-maker also records that he or she is willing to accept this role.

Part II -*General authorities of my surrogate decision-maker.*

In this part you record the authorities of your surrogate decision-maker when making decisions. You sign the statement you agree with. You cross out the statement you do not agree with. You can add additional authorities.

Part III - *My preferences concerning future medical care.*

In this part you record which decisions are important to you. You sign each statement you agree with. You cross out each statement you do not agree with. In this part you can also describe specific conditions that you consider important.

Part IV – *Signature.*

The last part concerns signing the document, in addition to your name, date and place.

**After the completion**

When you have completed and signed the advance directive, it is important that you provide copies to your surrogate decision-maker(s), your physician and others for whom this information is important (e.g. the institution where you live). This will increase chances that the advance directive can be used as appropriate.

**ADVANCE DIRECTIVE**

**Part I – Who makes decisions about my medical treatment in case I am no longer able to do this myself**

In this document I indicate who is allowed to make decisions about my medical treatment in case I am no longer able to do this myself. This person is my *surrogate decision-maker*.

**My surrogate decision-maker is:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number evening:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acceptance:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (first and last name) accepts the role as surrogate

decision-maker and will act on behalf of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (first and

last name) to the best of his/her abilities by making decisions that are in line with the preferences and wishes of the person described above.

In case my surrogate decision-maker no longer will or can decide on my behalf, **my surrogate decision-maker will be**:

**First alternative surrogate decision-maker**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number evening:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acceptance:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (first and last name) accepts the role as surrogate

decision-maker and will act on behalf of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (first and

last name) to the best of his/her abilities by making decisions that are in line with the preferences and wishes of the person described above.

In case this alternative surrogate decision-maker no longer will or can decide on my behalf, **my surrogate decision-maker will be:**

**Second alternative surrogate decision-maker**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number day:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number evening:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mobile phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acceptance:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (first and last name) accepts the role as surrogate

decision-maker and will act on behalf of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (first and

last name) to the best of his/her abilities by making decisions that are in line with the preferences and wishes of the person described above.

**Part II – General authorities of my surrogate decision-maker**

I give my surrogate decision-maker the following authorities:

*(Sign each statement you agree with and cross out* *each statement you do not agree with)*

\_\_\_\_\_ Make choices on my behalf concerning starting, continuing, or stopping medical treatment and procedures, such as tests, medication and surgeries.

\_\_\_\_\_ Discuss my preferences and wishes, as recorded in this document or indicated in conversations, with my medical practitioners.

\_\_\_\_\_ Give permission to disclose my medical records and other personal information, in case my physician considers it necessary for my medical treatment.

\_\_\_\_\_ Make decisions on my behalf about choosing a medical practitioner or place of care.

**Part III – My preferences concerning future medical care**

My surrogate decision-maker will make decisions that are in line with my preferences and wishes. In case it is unclear what I would have preferred in a specific situation, I want my surrogate decision-maker to make a decision, in consultation with my medical practitioners. In case my surrogate decision-maker cannot be reached, I want the following instructions to be followed.

**Cardiopulmonary resuscitation**

*(Sign the statement you agree with and cross out* *the statement you do not agree with)*

\_\_\_\_\_ I want to be resuscitated, unless my physician considers that medically futile

\_\_\_\_\_ I do not want to be resuscitated in case of a cardiac arrest

**Medical treatments**

*(Sign the statement you agree with and cross out* *the statement you do not agree with)*

When the doctor considers it likely, that I will no longer be capable of meaningful contact with my family, friends and others, I want:

\_\_\_\_\_ Full treatment as long as it makes sense

\_\_\_\_\_ Care that focuses on comfort, well-being and symptoms, not aimed at life-extension nor shortening of life.

In the situation as described above I want:

\_\_\_\_\_ Artificial feeding

\_\_\_\_\_ Hospital admission for medical treatment or surgeries

\_\_\_\_\_ Artificial ventilation

**Specific conditions for the situation in which life-prolonging medical treatment is foregone**

In this situation, I want further medical treatment and care focusing on comfort. The following aspects are important to me:

|  |
| --- |
|  |

**Specific conditions that apply when I choose the option “full treatment as long as it makes sense”**

If I choose the option “full treatment as long as it makes sense”, the following aspects are important to me:

|  |
| --- |
|  |

**Euthanasia, organ donation, body donation**

Because there are separate regulations for euthanasia, organ donation and body donation, these items are excluded from this advance directive.

**Part IV - Signature**

**I have completed this document voluntarily.**

Name:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date, place:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_