BayCare Health System | Morton Plant Mease Hospitals | St. Anthony's Hospital | St. Joseph's Hospitals South Florida Baptist Hospital

LIVING WILL &
APPOINTMENT OF HEALTHCARE SURROGATE

I, _____, want to choose how I will be treated by my physicians and other healthcare providers. If there comes a time when I am unable to communicate or make my own healthcare decisions because of illness or injury, I direct my physicians, my healthcare surrogate, and my family to honor this living will.

Part 1 – Appoint a Healthcare Surrogate

In the event I am unable to communicate or I am incapable of making decisions about receiving, withholding, or withdrawing medical procedures or other treatments, I designate my healthcare surrogate to make choices for me according to his/her understanding of my wishes and values.

My Appointed Healthcare Surrogate is:	
Name:	
Address:	
Phone:	Alt. Phone:

If my surrogate is unable or unwilling then my next choice (Alternate Surrogate) is:	
Name:	
Address:	
Phone:	Alt. Phone:

Part 2 – Indicate Your Wishes

I understand that this living will only becomes effective when I am no longer able to communicate or when I am not capable of making my healthcare decisions. When two physicians have determined that I have one of the following:

- ⇨ a terminal or end-stage condition, and there is little or no chance of recovery
- ⇨ a condition of permanent and irreversible unconsciousness, such as coma or vegetative state
- ⇨ an irreversible and severe mental or physical illness that prevents me from communicating with others, recognizing my family and friends, or caring for myself in any way

then I want my doctors and others to provide comfort (palliative) care including relief of all physical pain, suffocation and mental anguish. If I develop one of the above conditions, my treatment choices are:

My Specific Choices if I have one of the above conditions	**Yes I Want**	**No I Do Not Want**
	Circle Yes or No	
Cardio-pulmonary resuscitation (CPR) if my heart or breathing stops	Yes	No
A breathing machine if I am unable to breathe on my own	Yes	No
Nutrition and fluids through tubes in my veins, nose or stomach	Yes	No
Kidney dialysis, a pacemaker or defibrillator, or other such machines	Yes	No
Surgery or admission to a hospital Intensive Care Unit	Yes	No
Medications that can prolong my dying, such as antibiotics	Yes	No
I want Hospice involved in my care at the earliest opportunity	Yes	No

If a medical decision has to be made for me and my decision is not indicated above, I want my healthcare surrogate to make and communicate these decisions for me.

Other Information (optional):
Quality of life is important to me. These are the things that give my life quality:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Part 3 – Make It Legal

I fully understand the meaning of this declaration, I am emotionally and mentally competent to make this declaration, and have given this declaration careful consideration.

_____ _____ _____
Signature Date & Time Print Name

*Witness 1: _____ _____ _____
Signature of witness 1 Print Name Date & Time

Address: _____

*Witness 2: _____ _____ _____
Signature of witness 2 Print Name Date & Time

Address: _____

* Your healthcare surrogate(s) can not serve as a witness to this living will.
At least one witness must be someone other than your spouse or a blood relative.