DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 1996;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (1991). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

Lifecare Directives, LLC
5348 Vegas Drive
Las Vegas, NV 89108
www.lifecaredirectives.com
Toll Free: (877) 559-0527

~ Lifecare Directives ~

Statutory Advance Directive

For

Connecticut Residents

Statutory Compliant
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

For

Connecticut Residents

Statutory Compliant
Advance Directive for
Health Care Choices

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For Connecticut Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The Connecticut state legislature has provided statutes guiding the construction of both a living will and a Power of Attorney for Health Care for use by the public. Collectively, these documents are known as "advance directives." As the content of these documents was designed by your state government, each is in compliance with all applicable statutes and laws.

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read them carefully to ensure that your advance directives are fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize

the statement of the limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete each document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

SECTION I:

HEALTH CARE INSTRUCTIONS

Regarding Withholding and Withdrawal of Life-Support Systems

(CGS Title 19a: Vol.6: Ch.368w: §19a-570 to §19a-580d)

1. INTRODUCTION: *The Connecticut Living Will was designed to assist those wishing to refuse "life support systems" and other "beneficial medical treatment" in terminal or permanently unconscious conditions (§19a-571). A* ***terminal condition*** *is defined as,"the final stage of an incurable or irreversible medical condition which, without the administration of a life support system, will result in death within a relatively short time, in the opinion of the attending physician (§19a-570(11)). A* ***permanently unconscious condition*** *is defined as a "permanent coma and persistent vegetative state and means an irreversible condition in which the individual is at no time aware of himself or the environment and shows no behavioral response to the environment"(§19a-570(10)).*

Life support systems *include "any medical procedure or intervention which, when applied to an individual, would serve only to postpone the moment of death or maintain the individual in a state of permanent unconsciousness"(§19a-570(7)).* ***Beneficial medical treatment*** *is defined as, "medically appropriate treatment including surgery, treatment, medication and the utilization of artificial technology to sustain life"(§19a-570(4)). It is specifically noted that such treatment does not include "comfort care," which "shall be provided in all cases"(§19a-573).*

DOCUMENT CONCERNING HEALTH CARE AND WITHHOLDING OR WITHDRAWAL OF LIFE SUPPORT SYSTEMS

3. If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a testament of my wishes.

4. "I, _____, request that, if my condition is deemed terminal or if it is determined that I will be permanently unconscious, I be allowed to die and not be kept alive through life support systems. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment. The life support systems which I do ***not*** want include, but are not limited to:

    - Artificial respiration
    - Cardiopulmonary resuscitation
    - Artificial means of providing nutrition and hydration

    (*Cross out and initial life support systems you still want administered*)

    I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

Other specific requests

5. The following request(s) is/are made, after careful reflection, while I am of sound mind:

    _____
    _____
    _____
    _____
    _____
    _____
    _____
    _____
    _____

6. _____
    (Signature)

    _____
    (Date)

Statement of Witnesses

7. This document was signed in our presence, by the above-named individual, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time the document was signed.

8. Witness: _____

   Printed Name:_____

   Full Address: _____

9. Witness: _____

   Printed Name:_____

   Full Address: _____

SECTION II:
APPOINTMENT OF A HEALTH CARE AGENT AND ATTORNEY-IN-FACT
and Nomination of Guardian or Conservator

(Pursuant to CGS, Title 19a: Vol.6: Ch.368w: §19a-570 to §19a-580d)

10. INTRODUCTION: *Any person 18 years of age or older may execute a document which contains the appointment of a health care agent, the appointment of an attorney-in-fact for health care decisions, the nomination of a conservator for the person if ever needed, and a statement of organ and tissue donation wishes. Any person you name in this document must be 18 years of age or older. The document shall be signed and dated by the maker with at least two qualified witnesses*.

THESE ARE MY HEALTH CARE INSTRUCTIONS.
MY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE,
THE DESIGNATION OF MY CONSERVATOR OF THE PERSON
FOR MY FUTURE INCAPACITY
AND
MY DOCUMENT OF ANATOMICAL GIFT

To any physician who is treating me

11. These are my health care instructions including those concerning the withholding or withdrawal of life support systems, together with the appointment of my health care representative, the designation of my conservator of the person for future incapacity and my document of anatomical gift. As my physician, you may rely on these health care instructions and any decision made by my health care representative or conservator of my person, if I am incapacitated to the point where I can no longer actively take part in decisions for my own life, and am unable to direct my physicians as to my own medical care.

12. I, _____, the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state which is an irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment. The life support systems which I do not want include, but are not limited to: Artificial respiration, cardiopulmonary resuscitation and artificial means of providing nutrition and hydration. I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

Appointment of Agent

13. I appoint:

Name of Agent: _____

Address: _____

Telephone: Home:_____ Work:_____

Cell Phone or Pager: _____ E-mail: _____

~~ to be my health care representative.

14. *Representative Authorities*: If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, my health care representative is authorized to make any and all health care decisions for me, including the decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided by law, including but not limited to, psychosurgery or shock therapy, and the decision to provide, withhold or withdraw life support systems. I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes.

13. *Alternate Agent Appointment*: If the above named representative is unwilling or unable to serve as my health care representative, I appoint:

Name of Alternate: _____

Address: _____

Telephone: Home:_____ Work:_____

Cell Phone or Pager: _____ E-mail: _____

~~ to be my alternative health care representative.

Nomination of Conservator

14. If a conservator of my person should need to be appointed, I designate:

Name of Nominee: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

~~ to be appointed my conservator.

15. *Alternate Conservator Nominee*: If the above individual is unwilling or unable to serve as my conservator, I designate:

Name of Alternate Nominee: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

~~ No bond shall be required of either of them in any jurisdiction.

Organ and Tissue Donation

16. I hereby make the following anatomical gift of organs and/or tissues, if medically acceptable, to take effect upon my death.

I hereby give: (*check one*)

_____ (1) any needed organs or parts

_____ (2) only the following organs or parts: _____
_____
_____
_____
_____
_____

~~ to be donated for: (*check one*)

_____ (1) any of the purposes stated in subsection (a) of section 19a-279f of the general statutes; or,

_____ (2) only the following limited purposes: _____
_____
_____
_____
_____
_____

Validation of Directive

17. These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

Date _____, 20_____.

Signature: _____, L.S.

Statement of Witnesses

18. This document was signed in our presence by the author of this document, who appeared to be eighteen years of age or older, of sound mind and able to understand the nature and consequences of health care decisions at the time this document was signed. The author appeared to be under no improper influence. We have subscribed this document in the author's presence and at the author's request and in the presence of each other.

19. Witness: _____

Printed Name:_____

Full Address: _____

20. Witness: _____

Printed Name:_____

Full Address: _____

Affidavit of Witnesses

(optional)

State of CONNECTICUT)
County of)
)

21. We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointments of a health care agent and an attorney- in-fact, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request, and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request —

~~ this _____ day of _____ 20_____

22. Witness: _____

Printed Name:_____

Full Address: _____

23. Witness: _____

Printed Name:_____

Full Address: _____

24. Subscribed and sworn to before me —

~~ this _____ day of _____ 20_____

25. _____

Commissioner of the Superior Court or
Notary Public

26. My commission expires: _____

(*Print or type name of all persons signing under all signatures*)