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:

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~ Lifecare Directives ~

Statutory Advance Directive

For

Delaware Residents

Statutory Compliant
Advance Directive for
Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

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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 Delaware 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 Delaware legislature has provided statutes guiding the construction of both a Health Care Instruction (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 this document was drawn from the Uniform Health Care Decisions Act, it 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:

ADVANCE HEALTH CARE DIRECTIVE

(*Pursuant to Delaware Title 16, Part II, Chap.25: §2501 to §2518*)

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1. Introduction: *You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding anatomical gifts and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.*

Part 1 *of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional instructions for other than end of life decisions.*

Part 2 *of this form is a power of attorney for health care. Part 2 lets you name another individual as agent to make health-care decisions for you if you become incapable of making your own decisions. You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, an agent may not have a controlling interest in or be an operator or employee of a residential long-term health-care institution at which you are receiving care.*

If you do not have a qualifying condition (terminal illness/injury or permanent unconsciousness), your agent may make all health-care decisions for you except for decisions providing, withholding or withdrawing of a life sustaining procedure. Unless you limit the agent's authority, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition unless it's a life-sustaining procedure or otherwise required by law.

(b) Select or discharge health-care providers and health-care institutions; If you have a qualifying condition, your agent may make all health-care decisions for you, including, but not limited to:

(c) The decisions listed in (a) and (b).

(d) Consent or refuse consent to life sustaining procedures, such as, but not limited to, cardiopulmonary resuscitation and orders not to resuscitate.

(e) Direct the providing, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

***Part 3** of this form lets you express an intention to donate your bodily organs and tissues following your death.*

***Part 4** of this form lets you designate a physician to have primary responsibility for your health care.*

After completing this form, sign and date the form at the end. It is required that 2 other individuals sign as witnesses. Give a copy of the signed and completed form to your physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care and to any health-care agents you have named. You should talk to the person you have named as agent to make sure that the person understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health-care directive or replace this form at any time.

PART 1: INSTRUCTIONS FOR HEALTH CARE

(*If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out this part of the form. If you do fill out this part of the form, you may strike any wording you do not want*.)

(1) END-OF-LIFE DECISIONS: If I am in a qualifying condition, I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

Choice Not To Prolong Life. I do not want my life to be prolonged if:
(*initial if applies*)

(i)_____ I have a terminal condition (*an incurable condition caused by injury, disease, or illness which, to a reasonable degree of medical certainty, makes death imminent and from which, despite the application of life-sustaining procedures, there can be no recovery*) and regarding artificial nutrition and hydration.

Further, I provide the following specific ***terminal condition*** directions:

Regarding food provided through tubes or other medical devices:

(*initial only one*)

_____ I ***want*** artificial nutrition provided through a conduit.

_____ I do ***not*** want artificial nutrition provided through a conduit.

Regarding water provided through tubes or other medical devices:

(*initial only one*)

_____ I ***want*** artificial hydration provided through a conduit.

_____ I do ***not*** want artificial hydration provided through a conduit.

(ii)_____ I become permanently unconscious (*a medical condition that has been diagnosed in accordance with currently accepted medical standards that has lasted at least 4 weeks and with reasonable medical certainty as total and irreversible loss of consciousness and capacity for interaction with the environment. The term includes, without limitation, a persistent vegetative state or irreversible coma*) and regarding artificial nutrition and hydration,

Further, I provide the following specific ***permanent unconscious condition*** directions:

Regarding food provided through tubes or other medical devices:

(*initial only one*)

_____ I ***want*** artificial nutrition provided through a conduit.

_____ I do ***not*** want artificial nutrition provided through a conduit.

Regarding water provided through tubes or other medical devices:

(*initial only one*)

_____ I ***want*** artificial hydration provided through a conduit.

_____ I do ***not*** want artificial hydration provided through a conduit.

Choice To Prolong Life: Declaration to extend life, even in terminal and permanently unconscious conditions

(*initial if applies*)

_____ I want my life to be prolonged as long as possible within the limits of generally accepted health-care standards.

(2) RELIEF FROM PAIN: Except as I state in the following space, I direct treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

_____

_____

_____

_____

_____

_____

(3) OTHER MEDICAL INSTRUCTIONS: (*If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here*.) I direct that:

_____
_____
_____
_____
_____
_____

(*Add additional sheets if necessary*.)

PART 2:
POWER OF ATTORNEY FOR HEALTH CARE

(4) DESIGNATION OF AGENT: I designate the following individual as my agent to make health-care decisions for me:

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

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health-care decision for me, I designate as my first alternate agent:

Name of Alternate #1: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health-care decision for me, I designate as my second alternate agent:

Name of Alternate #2: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

(5) AGENT'S AUTHORITY: If I am not in a qualifying condition my agent is authorized to make all health-care decisions for me, except decisions about life-sustaining procedures and as I state here; and if I am in a qualifying condition, my agent is authorized to make all health-care decisions for me, except as I state here:

_____
_____
_____
_____
_____
(*Add additional sheets if necessary*.)

(6) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines I lack the capacity to make my own health-care decisions. As to decisions concerning the providing, withholding and withdrawal of life-sustaining procedures my agent's authority becomes effective when my primary physician determines I lack the capacity to make my own health-care decisions and my primary physician and another physician determine I am in a terminal condition or permanently unconscious.

(7) AGENT'S OBLIGATION: My agent shall make health-care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(8) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, (*please initial one*):

_____ I nominate the agent(s) whom I named in this form in the order designated to act as guardian.

OR,

_____ I nominate the following to be guardian:

Name:_____

Address: _____

Telephone: Home:_____ Work:_____

Cell Phone or Pager: _____ E-mail: _____

OR,

_____ I do not nominate anyone to be guardian.

PART 3:
ANATOMICAL GIFTS AT DEATH
(*OPTIONAL*)

(9) I am mentally competent and 18 years or more of age. I hereby make this anatomical gift to take effect upon my death. The marks in the appropriate squares and words filled into the blanks below indicate my desires. I choose to give:

_____ my entire body;
_____ any needed organs or parts;
_____ the following organs or parts;

To the following person or institutions:

_____ the physician in attendance at my death;
_____ the hospital in which I die;
_____ the following named physician, hospital, storage bank or other medical institution _____;
_____ the following individual for treatment;

For the following purposes:

_____ any purpose authorized by law;
_____ transplantation;
_____ therapy;
_____ research;
_____ medical education.

PART 4:
PRIMARY PHYSICIAN
(*OPTIONAL*)

(10) I designate the following physician as my primary physician:

Name: _____
Facility/Office: _____
Address _____
Phone: _____

OPTIONAL: If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

Name: _____
Facility/Office: _____
Address:_____
Phone: _____

Primary Physician shall mean a physician designated by an individual or the individual's agent or guardian, to have primary responsibility for the individual's health care or, in the absence of a designation or if the designated physician is not reasonably available, a physician who undertakes the responsibility.

(11) EFFECT OF COPY: A copy of this form has the same effect as the original.

(12) SIGNATURE: Sign and date the form here: I understand the purpose and effect of this document.

(*Do not sign until in the presence of two qualified witnesses; see below*)

Signed:_____ Date: _____

Printed Name: _____

Address _____

(13) SIGNATURES OF WITNESSES:

Statement Of Witnesses

SIGNED AND DECLARED by the above-named declarant as and for the declarant's written declaration under 16 Del.C. §§ 2502 and 2503, in our presence, who in the declarant's presence, at the declarant's request, and in the presence of each other, have hereunto subscribed our names as witnesses, and state:

A. That the Declarant is mentally competent.

B. That neither of them:

1. Is related to the declarant by blood, marriage or adoption;
2. Is entitled to any portion of the estate of the declarant under any will of the declarant or codicil thereto then existing nor, at the time of the executing of the advance health care directive, is so entitled by operation of law then existing;
3. Has, at the time of the execution of the advance health-care directive, a present or inchoate claim against any portion of the estate of the declarant;
4. Has a direct financial responsibility for the declarant's medical care;
5. Has a controlling interest in or is an operator or an employee of a residential long-term health-care institution in which the declarant is a resident; or
6. Is under eighteen years of age.

C. That if the declarant is a resident of a sanitarium, rest home, nursing home, boarding home or related institution, one of the witnesses, _____, is at the time of the execution of the advance health-care directive, a patient advocate or ombudsman designated by the Division of Services for Aging and Adults with Physical Disabilities or the Public Guardian.

(14) I am not prohibited by § 2503 of Title 16 of the Delaware Code from being a witness.

1st Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)

(15) I am not prohibited by § 2503 of Title 16 of the Delaware Code from being a witness.

2nd Witness: _____
(Signature)

_____ _____
(Name Printed) (Date)

_____
(Residence Address)