Advance Directives

Frequently Asked Questions

Who can make an advance directive?

Any person who has the capacity to make his or her own medical decisions, including competent adults 18 years or older and emancipated minors.

Why should I make an advance directive?

An advance directive speaks for you when you are unable to do so and directs your wishes regarding healthcare decisions. Because it tells others the care and treatments you do or do not want and/or who will make healthcare decisions for you when you cannot express your wishes, it may relieve your family from the burden of guessing what you would want.

Does my healthcare provider have to follow my advance directive?

Some healthcare providers and physicians may have policies or beliefs that prohibit them from honoring certain advance directives. It is important to discuss your advance directive with these providers to make them aware of your wishes and to determine if they will honor your advance directive. If a physician or other provider is unwilling to honor your wishes, he or she must make a good faith effort to refer you to a physician or other provider who will meet your needs.

What happens if I don't make an advance directive?

You will receive care if you do not make an advance directive. If you cannot speak for yourself and have not made an advance directive, a physician will generally look to your family or friends for decisions about your care. If the physician or healthcare facility is unsure, or if your family is in disagreement about the decision, they may ask a court to appoint a person (guardian) who will make decisions for you.

Where should I keep my advance directive?

You should keep your advance directive in a readily accessible place where family/friends can locate it. You should make sure your family members, your physician and your lawyer, if you have one, know you have made an advance directive and know where it is located. Bring a copy of this document when you are hospitalized.

What authority does my healthcare surrogate have to make decisions for me?

Except for any restrictions you have placed on their authority, your healthcare surrogate has the right to make all healthcare decisions for you, including the right to refuse medical treatment. They also have the right to review your medical records and receive from your physician all information about your condition, prognosis and treatment options as is necessary for them to make an informed decision.

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Why is it important to designate a healthcare surrogate?

You may become unable to make your own healthcare decisions because of a serious injury, illness or disease. If you cannot make your own healthcare decisions, someone will have to make them for you, and without a healthcare surrogate, your physician will not know who you want that person to be. Having a healthcare surrogate will help ensure your preferences are respected because only the person you have appointed will be able to make healthcare decisions on your behalf. Also, having a healthcare surrogate will help prevent conflicts among your family members who may disagree on who should have the authority to make these decisions. Even if you have a living will, it is important to have a healthcare surrogate, because there are many circumstances in which treatment decisions will have to be made that are not covered by your living will.

Whom should I appoint as my healthcare surrogate?

You can appoint your spouse/domestic partner, parent, adult child, family member, friend, religious/spiritual adviser or any other adult. You should choose someone who knows your values, beliefs and preferences well enough to know what treatment decisions you would want them to make for various medical conditions. The person should be someone with good judgment and who will be a strong advocate on your behalf. They should also be someone you believe will respect your wishes even if they disagree with them, especially when it comes to your preferences about the use of life-sustaining treatment.

What happens if I regain the ability to make my own decisions?

In that case, your physician must obtain your consent for all treatment. Once you have the ability to make healthcare decisions, your healthcare surrogate will no longer have the authority to make decisions for you.

What if I change my mind?

You can cancel or replace a living will and/or designation of healthcare surrogate at any time. To cancel it you need to tell your physician, family, healthcare representative, nurse, social worker or a reliable witness that you want to cancel your advance directive. You can tell them verbally or send them a letter.

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PERSONAL CHOICES & PATIENT BILL OF RIGHTS

Your Right to Decide and Make Your Wishes Known

Consent for Treatment

Before you can be treated for your medical condition in the hospital, you or your representative (healthcare surrogate) will be asked to sign Consent for Treatment forms. These forms provide your written consent for diagnostic lab work, tests, procedures or surgery. Please be sure you read and understand the information before you sign the forms.

Advance Directives

An "advance directive" is a document that you may fill out before you need hospitalization. It designates how you want your healthcare to be delivered in the event that you are not able to make that decision yourself. It also allows you to name a trusted person to make these choices for you. These forms are provided as a courtesy if you do not already have advance directives. Two forms of advance directives are:

- A Living Will
- Healthcare Surrogate Designation

If you have questions or need help, please contact the Spiritual Care Department at the hospital where you are staying or the Risk Management Department at (321) 841-5294.

Living Will

A living will generally states the type of medical care you want or do not want if you become unable to make your own decisions. It is called a "living" will because it takes effect while you are still living. Under Florida law, you may make a living will and direct the providing of or withholding or withdrawal of life-prolonging procedures in the event that you:

- have a terminal condition caused by injury, disease or illness from which there is no reasonable medical probability of recovery and that, without treatment, can be expected to cause death, or
- have an end-stage condition caused by injury, disease or illness that has resulted in progressively severe and permanent deterioration and, to a reasonable degree of medical probability, treatment of the condition would be ineffective, or
- are in a persistent "vegetative" state, or permanent and irreversible condition of unconsciousness in which there is:
  (a) the absence of voluntary action or cognitive behavior of any kind;
  (b) an inability to communicate or interact purposefully with the environment.

Healthcare Surrogate

A healthcare surrogate form is a signed, dated and witnessed document naming another person such as a spouse, adult child, other family member, or close friend as your representative to make medical decisions for you if you become unable to make them yourself or if you choose to defer the decisions to the person you designate even if you have the capacity to make your own decisions. You can include instructions about any treatment you want or wish to avoid. Florida law provides a suggested form for designation of a healthcare surrogate or you may use the form included in this guide. If your health care surrogate is not willing, able, or reasonably available to perform his or her duties, you may also name an alternate healthcare surrogate.

Summary of the Florida Patient's Bill of Rights and Responsibilities

In order to promote the interests and well-being of our patients, Orlando Health recognizes your rights while you are receiving medical care. We trust that you will respect Orlando Health's right to expect certain behavior of you while you are a patient at our facility. The following is a summary of your rights and responsibilities in accordance with the Florida Patient Bill of Rights and federal regulations.

Your Rights

You have the right to:

- be treated with courtesy and respect, with appreciation of your individual dignity and with protection of your need for privacy.
- a prompt and reasonable response to questions and requests.
- know who is providing medical services and who is responsible for your care.
- know what patient support services are available, including that an interpreter is available at no cost to you if you do not read, speak or understand English or have a disability affecting your ability to communicate.
- bring any person of your choosing to the patient-accessible areas of the health care facility or provider's office to accompany you while receiving inpatient or outpatient treatment or while consulting with your health care provider, unless doing so would risk your safety or health or the safety or health of other patients, or staff of the facility or office or cannot be reasonably accommodated by the facility or provider.
- know what rules and regulations apply to your conduct.
- be given by the healthcare provider information concerning your diagnosis, planned course of treatment, alternatives, risks and prognosis.
- appropriate assessment and management of pain.
- designate a support person, determine who may visit, and understand there may be limitations placed on visits in accordance with clinical considerations.
- refuse treatment, except as otherwise provided by law.
- be given, upon request, full information and necessary counseling on the availability of known financial resources for your care.
- (if eligible for Medicare) know, upon request in advance of treatment, whether the healthcare provider or health care facility accepts the Medicare assignment rate.
- receive, upon request, prior to treatment, a reasonable estimate of charges for medical care.
- receive a copy of a reasonable, clear and understandable itemized bill and upon request, to have charges explained.
- impartial access to medical treatment or accommodations, regardless of race, national origin, religion, sexual orientation, handicap, age or source of payment.
- treatment for any emergency medical condition that will deteriorate from failure to provide treatment.
- know if medical treatment is for purposes of experimental research and to give your consent or refusal to participate in such experimental research.
- express complaints/grievances regarding any violation of your rights, as stated in Florida or federal law, through Orlando Health using the complaint/grievance hot line (321) 841-5294 and to the appropriate state licensing agency.

Your Responsibilities

You are responsible for:

- providing to Orlando Health, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters relating to your health.
- reporting unexpected changes in your condition to Orlando Health.
- reporting to Orlando Health whether you understand a contemplated course of action and what is expected of you.
- following the treatment plan recommended by Orlando Health.
- keeping appointments and, when you are unable to do so for any reason, for notifying the healthcare provider or healthcare facility.
- your actions, if you refuse treatment or do not follow the healthcare provider's instructions.
- ensuring that the financial obligations of your medical care are fulfilled as promptly as possible.
- following Orlando Health's rules and regulations affecting your care and conduct.

For a copy of the full text of the Florida Patient's Bill of Rights and Responsibilities, please ask your nurse or ask to speak with a Risk Management representative.

If you have any complaint against a hospital or ambulatory surgical center, call the Complaint Administration Unit at (888) 419-3456 or write to the address below:

Agency for Healthcare Administration
Consumer Assistance Unit
2727 Mahan Drive
Tallahassee, FL 32317-4000
www.fdhc.state.fl.us

If you have complaints against a doctor, call Medical Staff Services at (407) 841-5139 or the Medical Quality Assurance, Consumer Service Office at (888) 419-3456 or write to the address below:

Healthcare Practitioners
Medical Quality Assurance
Consumer Services
P.O. Box 1400
Tallahassee, FL 32308-4000

If you have concerns related to patient care or safety not addressed by the hospital's management contact:

Joint Commission
Office of Quality Monitoring
One Renaissance Blvd
Oakbrook, IL 60181
(800) 994-6610
www.jointcommission.org

Living Will

Declaration made this _____ day of _____ (enter year) _____ .

I, _____ willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that, if at any time I am incapacitated and

(initial) _____ I have a terminal condition: a condition caused by injury, disease or illness from which there is no reasonable medical probability of recovery and that, without treatment, can be expected to cause death; or

(initial) _____ I have an end-stage condition: an irreversible condition caused by injury, disease or illness that has resulted in progressively severe and permanent deterioration, and that to a reasonable degree of medical probability, treatment of the condition would be ineffective; or

(initial) _____ I am in a persistent "vegetative" state: a permanent and irreversible condition of unconsciousness in which there is: (a) the absence of voluntary action or cognitive behavior of any kind; (b) an inability to communicate or interact purposefully with the environment;

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such a condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of my dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

In the event that I have been determined to be unable to provide express and informed consent regarding the withholding, withdrawal or continuation of life-prolonging procedures, I wish to designate as my surrogate to carry out the provisions of this declaration:

Name _____

Address _____

Phone Number _____

If the above-named person is not available, I designate:

Name _____

Address/Phone Number _____

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Additional Instructions (optional) _____

_____

Name (print) _____ Signed _____

Witness Name (print) _____ Witness Signature _____

Address/Phone _____

Witness Name (print) _____ Witness Signature _____

Address/Phone Number _____

DESIGNATION OF HEALTHCARE SURROGATE FOR ADULT

Name: _____
LAST FIRST MI

I wish to designate as my healthcare surrogate:

Name: _____

Address: _____

State/Zip: _____/_____ Phone: _____

If my healthcare surrogate is unwilling, unable or not reasonably available to perform his/her duties, I designate as my alternate healthcare surrogate:

Name: _____

Address: _____

State/Zip: _____/_____ Phone: _____

I authorize my health care surrogate to:

1. Receive any of my health information, whether oral or recorded in any form or medium and relates to my past, present, or future physical or mental health or condition; the provision of health care to me; or the past, present, or future payment for the provision of health care to me.
2. Provide informed consent, refusal of consent, or withdrawal of consent to any and all of my health care, including life-prolonging procedures.
3. Apply on my behalf for private, public, government, or veterans' benefits to defray the cost of health care.
4. Decide to make an anatomical gift pursuant to part V of chapter 765, Florida Statutes.
5. Additional Instructions and Restrictions: (optional) _____

_____

_____

While I have decision-making capacity, my wishes are controlling and my physicians and health care providers must clearly communicate to me the treatment plan or any change to the treatment plan prior to its implementation.

To the extent I am capable of understanding, my health care surrogate shall keep me reasonably informed of all decisions that he or she has made on my behalf and matters concerning me.

I understand that I may, at any time while I retain my capacity, revoke or amend this designation by:

(1) signing a written and dated declaration which expresses my intent to amend or revoke this designation;

(2) physically destroying this designation through my own action or by that of another person in my presence and under my direction;

(3) verbally expressing my intention to amend or revoke this designation; or

(4) signing a new designation that is different from this designation.

MY HEALTHCARE SURROGATE'S AUTHORITY BECOMES EFFECTIVE WHEN MY ATTENDING/MANAGING PHYSICIAN DETERMINES THAT I AM UNABLE TO MAKE MY OWN HEALTHCARE DECISIONS UNLESS I INITIAL THE FOLLOWING:

_____ (initial here) MY HEALTH CARE SURROGATE'S AUTHORITY TO RECEIVE MY HEALTH INFORMATION TAKES EFFECTIVE **IMMEDIATELY**.

_____ (initial here) MY HEALTHCARE SURROGATE'S AUTHORITY TO MAKE HEALTHCARE DECISIONS FOR ME TAKES EFFECT **IMMEDIATELY**.

ANY INSTRUCTIONS OR HEALTH CARE DECISIONS I MAKE, EITHER VERBALLY OR IN WRITING, WHILE I POSSESS CAPACITY, SHALL OVERRIDE ANY INSTRUCTIONS OR HEALTH CARE DECISIONS MADE BY MY SURROGATE THAT ARE IN CONFLICT WITH THOSE MADE BY ME.

Printed Name: _____

Signature: _____ Date: _____ Time: _____

Witness Name: _____

Witness
Signature: _____ Date: _____ Time: _____

Witness Name: _____

Witness
Signature: _____ Date: _____ Time: _____

(At least one witness must be neither a spouse nor a blood relative of the signatory)