ADVANCED CARE PLAN

I,_____**, Patient**, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following persons, in the listed order of priority, to make health care decisions for me. My agent can make any decision for me which I could have made myself, if able, *except* that my agent must follow my instructions below. Pursuant to CFR § 164.508, my agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

Name:_____ Phone #: _____

PRIMARY HEALTH CARE AGENT

Address:_____ Relation: _____

FIRST ALTERNATE	SECOND ALTERNATE
_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City, State Zip Code	City, State Zip Code
_____	_____
Telephone Number	Telephone Number
_____	_____
Telephone Number	Telephone Number
Relation: _____	Relation: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate comfort care and pain management.

A quality of life that is unacceptable to me is when I have any of the following conditions which I have checked or marked. I do not want to linger in any condition I have indicated to be unacceptable to me.

Q **Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

Q **Permanent Confusion:** I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

Q **Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.

Q **End-Stage Illnesses**: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows.

Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.

Q Yes Q No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
Q Yes Q No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
Q Yes Q No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
Q Yes Q No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions, such as burial arrangements, hospice care, etc.: _____

_____

Funeral Arrangements. This document gives my healthcare agent the power after I die to make arrangements for the disposition of my body for funeral arrangements, burial or cremation, including the purchase of a burial plot, marker, columbarium, urn, memorial plot, vault or similar mode and method of repository for my body or ashes.

Organ donation (optional): Upon my death, I wish to make the following anatomical gift:
Q None; Q Any organ/tissue; Q My entire body;
Q Only the following organs/tissues:_____

SIGNATURE: _____ DATE: _____

STATE OF TENNESSEE
COUNTY OF _____
I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "Patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My Commission Expires: _____ _____
NOTARY PUBLIC