

We all have *wishes*.

We also have *choices*.



*My Choices*

An Advance Directive for Health Care Choices

## *My Choices*, an advance directive

*My Choices* can help you if you are ever too sick or injured to make your own medical decisions. This advance directive contains both a living will and a power of attorney for health care. As long as you are well enough, you make medical decisions for yourself. If you are ever unable to do so, *My Choices* legally transfers medical decision-making authority from you to your designated Representative and states your end-of-life care wishes. You do not need a lawyer to complete this form, though you may wish to consult one. It is important to note that your *My Choices* form is not set in stone. You can change your mind by simply completing a new *My Choices* form.

*My Choices* was created for Montana adults according to Montana law by a task force of citizens, doctors, nurses, lawyers, faith leaders, and advocates. It is designed to make advance care planning easier to complete and easier for health care providers to follow. *My Choices*

has become the standard in several hospitals and other health care facilities around Western Montana.

An advance directive can be much more than a legal document that ensures medical decisions honor your wishes. This booklet is designed to help you discuss medical treatment and end-of-life choices with your loved ones and health care providers. If you need help completing the *My Choices* form, contact your doctor or one of the organizations listed on the back cover.

*“I did this as much for my family as for myself.”*



*Two men are in separate hospital rooms on the same floor. Each is dying. Both are unconscious. Both are surrounded by family. In one room, the family is arguing over their loved one's medical treatment.*

*“What should we do? What would*

*he have wanted?” In the other room, the family is sharing memories of their loved one. They are telling stories. They are grieving. But they are at peace because they know what his wishes are and that they are being honored. Now imagine one of these men is your father. Which situation would you choose?*

## TERMS TO KNOW

**Advance care planning:** Decision-making process about care you would want to receive if you were unable to communicate or make decisions for yourself. Based on understanding your values, personal reflection, and discussion with loved ones, health care providers, and others.

**Advance directive:** A legal document that provides directions for your health care if you are not able to speak for yourself or make decisions. Can include both power of attorney for health care and living will.

**Living will:** Your directions to health care providers for the end-of-life treatment you do and do not want if you are terminally ill, cannot speak or make decisions for yourself and are near death.

**Power of attorney:** A document appointing another person to make financial or business decisions. A

power of attorney can be specially prepared so that it is valid if you ever become incapacitated. Also known as a “durable power of attorney.”

**Power of attorney for health care:** A document appointing another person you choose as your Representative to make all health care decisions for you at any point in your life if you cannot speak or make your own decisions. Also known as a “durable power of attorney for health care.”

**Representative:** A person appointed in a power of attorney for health care to make health care decisions for you only if you cannot communicate or make decisions for yourself. Also called an agent, surrogate, or proxy.

**Will:** A document that states how you wish your possessions to be disposed of after your death.

*“You don’t have to be old to get sick. You don’t have to be old to get injured.”*

*A woman, age 23, is climbing in the Mission Mountains when she falls 60 feet to a ledge below. Her injuries are life threatening. She is rescued from the ledge and flown to the hospital.*



*She is unconscious. You are her husband. The doctors tell you she is not likely to ever regain consciousness, though with machines she could be kept alive for quite some time. Would you know what she would have wanted?*

## *Why complete a My Choices advance directive?*

An advance directive allows you to maintain control over your own medical care even if you cannot speak for yourself or make your own decisions (temporarily or permanently).

The *My Choices* booklet is also designed to help you create an advance directive that reflects your ideals, beliefs, and choices. As important as it is to put your wishes on paper, *My Choices* isn’t meant to be kept to yourself.

It is imperative you share a copy of your completed advance directive with your family,

your health care Representative, primary care physician, and others who are important to you. Sharing the directive helps ensure your wishes will be honored. But there are other reasons to discuss *My Choices* with your family, friends, and caregivers.

Studies show that the stress of making health care decisions for a loved one—when that individual is incapable of doing so—is more than double the stress of losing that person. However, the stress is greatly reduced if the decision maker knows that he or she is following the patient’s wishes.

In other words, an advance directive isn’t only something you do to ensure your wishes are followed; it’s also something you do for the people you care about.

*Please remove the form and continue reading.*

# My Choices

## Advance Directive for Health Care

\_\_\_\_\_

*Print your full name,*

\_\_\_\_\_

*Date of birth, and*

\_\_\_\_\_

*Social Security number.*

**These directions apply only in situations when I am not able to make or communicate my health care choices directly.** *[Put an X through any sections you are not completing at this time.]*

### I. Health Care Representative (Power of Attorney for Health Care)

My Representative may make ALL health care decisions for me as authorized in this document and shall be given access to all my medical records. This appointment applies whether I am expected to recover or not.

**I wish to appoint a Representative:**  Yes  No *[Go to Part II.]*

#### A. Primary Representative

I appoint \_\_\_\_\_ as my Representative.  
*Print Representative's Full Name*

Representative's Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

My Representative's authority is effective when I cannot make health care decisions or communicate my wishes. I may revoke this authority at any time I regain these abilities (unless my attending physician and any necessary experts determine I am not capable of making decisions in my own best interest).

If, for any reason, I should need a guardian of my person designated by a court, I nominate my Representative, or Alternate Representative(s), named below.

#### B. Alternate Representatives

- If:** 1) I revoke my Representative's authority; **or**  
2) My Representative becomes unwilling or unable to act for me; **or**  
3) My Representative is my spouse and I become legally separated or divorced,

I name the following person(s) as alternates to my Representative in the order listed.

1. \_\_\_\_\_ 2. \_\_\_\_\_  
*Print Alternate Representative's Full Name* *Print Alternate Representative's Full Name*

Address \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Ph \_\_\_\_\_ Work \_\_\_\_\_ Home Ph \_\_\_\_\_ Work \_\_\_\_\_

Print your full name.

## II. Terminal Conditions (Living Will)

I provide these directions in accordance with the Montana Rights of the Terminally Ill Act. These are my wishes for the kind of treatment I want **if I cannot communicate or make my own decisions**. These directions are **only valid if BOTH** of the following two conditions exist. **IF:**

1) **I have a terminal condition;**

**AND**

2) **In the opinion of my attending physician, I will die in a relatively short time without life sustaining treatment which only prolongs the dying process.**

I authorize my Representative, if I have appointed one, to make the decision to provide, withhold, or withdraw any health care treatment.

### General Treatment Directions *[Check the boxes that express your wishes.]*

- I provide no directions at this time.
- I direct my attending physician to **withdraw or withhold treatment that merely prolongs the dying process.**

I further direct that: *[Check all boxes that apply.]*

- Treatment be given **to maintain my dignity, keep me comfortable, and relieve pain even if it shortens my life.**
  - If I **cannot drink, I do not want to receive fluids** through a needle or catheter placed in my body unless for comfort.
  - If I **cannot eat, I do not want a tube** inserted in my nose, mouth, or surgically placed in my stomach to give me food.
  - If I have a **serious infection, I do not want antibiotics** to prolong my life. Antibiotics may be used to treat a painful infection.
- 
- I have attached additional directions regarding medical treatment to this form.
  - I have **not** attached additional directions to this form at this time.

## III. I Have a Chronic Illness or Serious Disability *(Optional)*

My chronic illness or disability can complicate an acute illness, but should not be misinterpreted as a terminal condition.

A. **Diagnosis:** \_\_\_\_\_

B. **Consult my physician.** *[Name, phone]* \_\_\_\_\_

C. **Special directions.** *[Use additional pages if necessary.]* \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## IV. Signing, Witnessing This Advance Directive

**A. Your Signature** *[Ask two people to watch you sign and have them sign below. If you can, it's best to sign this document in front of a Notary Public.]*

1. I revoke any prior health care advance directive or directions.
2. This document is intended to be valid in any jurisdiction in which it is presented.
3. A copy of this document is intended to have the same effect as the original.
4. Those who act as I have directed in this document shall be free from legal liability for having followed my directions.
5. If my attending physician is unwilling or unable to comply with my wishes as stated in this document, I direct my care be transferred to a physician who will.

I sign this document on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
*Signature* *Print Full Name*

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

### B. Ask Your Witnesses to Read and Sign

I declare that the person who signed this document is personally known to me, and has signed these health care advance directives in my presence, and appears to be of sound mind and under no duress, fraud, or undue influence.

As a witness, I am **NOT**:

- The person appointed as Representative by this document;
- Financially responsible for this person's health care;
- Related to this person by blood, marriage, or adoption; and
- To the best of my knowledge, entitled to inherit any part of this person's estate under a will now existing or by operation of law.

1. _____	2. _____
<i>Signature</i>	<i>Signature</i>
<i>Date</i>	<i>Date</i>
Name _____	Name _____
Address _____	Address _____
City _____	City _____
State _____ Zip _____	State _____ Zip _____

### C. Notarizing This Document *(Optional, but recommended)*

STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, the said known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public within and for the State and County aforesaid, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.

\_\_\_\_\_  
\_\_\_\_\_  
Notary Public for the State of \_\_\_\_\_  
Residing at \_\_\_\_\_  
My commission expires: \_\_\_\_\_

## V. Special Directions

### A. Spiritual Preferences

My religion: \_\_\_\_\_ My faith community: \_\_\_\_\_  
Contact person: \_\_\_\_\_ I would like spiritual support.  Yes  No

**B. Where I would like to be when I die:**  My home  Hospital  Nursing home  
 Other: \_\_\_\_\_

### C. Donation of Organs at My Death

- I do **not** wish to donate any of my body, organs, or tissue.  
 I wish to donate **my entire body**.  
 I wish to donate **only** the following: *[Check all that apply.]*
- |   |                                |                                  |  |
|---|--------------------------------|----------------------------------|--|
| <input type="checkbox"/> Any organs, tissues, or body parts | <input type="checkbox"/> Heart | <input type="checkbox"/> Kidneys | <input type="checkbox"/> Lungs                                   |
| <input type="checkbox"/> Bone marrow                        | <input type="checkbox"/> Eyes  | <input type="checkbox"/> Skin    | <input type="checkbox"/> Liver <input type="checkbox"/> Other(s) |

**D. After Death Care:** *[Care of my body, burial, cremation, funeral home preference]*

\_\_\_\_\_

**E. Additional Directions:** *[Use additional pages if necessary.]* \_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

### F. Distributing This Advance Directive

**I plan to deposit this Advance Directive in the Choices Bank:**  Yes  No

I plan to send copies of this document to the following people or locations:

<b>Physician:</b> _____	<b>Family Member:</b> Relationship _____
Name _____	Name _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Home Ph _____ Work _____	Home Ph _____ Work _____

<b>Hospital:</b> _____	<b>Clergy:</b> _____
Name _____	Name _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Phone _____	Home Ph _____ Work _____

*My Choices* was created by the Advance Care Planning Task Force of the Life's End Institute: Missoula Demonstration Project (406/728-1613). Members of this task force represent Missoula hospitals, home care agencies, hospice, long-term care facilities, Missoula Aging Services, Coalition of Montanans Concerned with Disabilities, AARP, public health, physicians, nurses, physician assistants, social workers, emergency medical technicians, attorneys, and clergy. Version 3.1. A copy of *My Choices* can be printed from [www.choicesbank.org](http://www.choicesbank.org).

## Who should have a *My Choices* advance directive?

Everyone over the age of 18 can benefit from completing *My Choices*. Being too weak or confused to make medical decisions can happen at any age. Still, there are points in life when people are more likely to consider or have the opportunity to complete a *My Choices* advance directive: prior to a hospital stay, after the death of a loved one, when creating or revising a will, after retirement, or when entering a long-term care facility.

Because life goals and values often evolve as we age, *My Choices* is meant to be a changeable, evolving document. People who complete advance directives often review and alter them as their wishes, health, and lives change. Even if there are no dramatic changes in your life or health, we suggest reviewing

your advance directive annually to make sure it continues to reflect your wishes.

## Is *My Choices* all I need to ensure my wishes are honored?

You can help ensure your wishes will be honored by doing three things. First, complete the *My Choices* form and sign it in front of two witnesses. Second, talk about it and your wishes with your Representative, close family members and friends, your doctor, and anyone else who is important to you. And, third, deposit a copy of your *My Choices* form in the Choices Bank, a free service that makes it available anytime, anywhere, but only to health care providers and those you choose.

## To ensure your advance directive is honored:

- **Notarize your advance directive.** While most states will accept your advance directive, notarizing helps prove the document's authenticity and can help avoid confusion.
- **Check states you travel to frequently.** Since it is a legal document valid in Montana, *My Choices* should be honored when you travel in all states. If you live part of the year in another state, visit [www.partnershipforcaring.org](http://www.partnershipforcaring.org) or call (800) 989-9455 for state-specific forms.
- **Discuss your choices with several people.** Obviously, it is imperative to discuss your advance directive with your Representative. It is also important to discuss it with your doctor, family, and others who are important to you. The more people who know your wishes, the more likely they are to be honored.
- **Deposit it in the *Choices Bank*.** Bring your advance directive to a Choices Bank location. For details visit [www.choicesbank.org](http://www.choicesbank.org) or call (406) 329-2707. When you receive your Choices Bank cards, put one in your wallet, give one to your Representative, and share this information with your loved ones and doctor.
- **Review your advance directive annually.** Your directive may become outdated. For example, your Representative or Alternate Representatives may have a new address or phone number. Even if you don't change anything, it is best to review your directive annually, or more frequently if you have significant life or health changes.

For another copy of *My Choices*, go to [www.choicesbank.org](http://www.choicesbank.org).

# Advance health care planning, a four-step process.

## *1. Determine your goals for medical treatment.*

While it is impossible to anticipate all of the different medical decisions that may come up, you can make your preferences clear by stating your goals for medical treatment.

What do you want treatment to accomplish? Do you want it to prolong your life whatever the quality? If life-sustaining treatment could not restore consciousness or your ability to communicate, would you prefer to be kept comfortable rather than receive life-prolonging treatment?

In forming your treatment goals, it is often helpful to consider your wishes about different end-of-life treatments. With these goals in mind, would you want to be kept alive with a feeding tube, intravenous fluids, or antibiotics? The answers to these kinds of questions will reflect important values that you hold and will help you shape your goals of treatment.

Knowing your goals for treatment will make it easier for your family and physicians to make medical decisions on your behalf, should you ever become unable to make your own decisions. If a given treatment would help achieve your goals, it would likely be provided. If not, the treatment most likely would not be provided.

*The following questions may help in determining your values and goals.*

How do you feel about your current health?

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How important are independence and self-sufficiency in your life?

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How do you imagine handling illness, disability, dying, and death?

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How might your personal relationships affect medical decision making, especially near the end of life?

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What role should doctors and other health professionals play in such decisions?

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What kind of living environment would be acceptable to you if you became seriously ill or disabled? Would you want to live in a nursing home or assisted living facility? Receive in-home care?

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How much should the cost to your family be a part of the decision-making process?

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What role do religious or spiritual beliefs play in decisions about your health care?

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What are your thoughts about living life's final stages? What are your hopes and fears?

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## ***2. Choose your Representative.***

Choosing your Representative is the most important part of this process. He or she will have great power over your health and personal care if you cannot make your own decisions.

*When choosing a Representative, think about these questions:*

- A. Is this person willing to be your Representative?***
- B. Have you discussed your life values and health care wishes with this person?***
- C. Is he or she willing to and capable of following your directions?***
- D. Can this person make difficult decisions when under stress?***

Choose one person to serve as your Representative to avoid disagreements. If you appoint two or more Representatives to serve together and they disagree, your health care providers will have no clear direction. If possible, appoint at least one Alternate Representative in case your Representative is not available.

Take the time to have heart-to-heart conversations with your Representative and each alternate. Let other close family members know whom you have chosen and why.

If you can think of no one you trust to carry out this responsibility, then do not name a Representative. Make sure, however, that you provide instructions that will guide your doctor or a court-appointed decision maker.

## ***3. Complete the My Choices form.***

An advance directive does not have to give directions or guidelines to your Representative.

However, if you have specific wishes or preferences, you should spell them out in the document itself. You may add additional pages to the form if necessary.

No matter how much direction you provide, your Representative will still need considerable discretion and flexibility. Write instructions carefully so they do not restrict the authority of your Representative in ways you do not intend.

## ***4. Deposit it in the Choices Bank.***

The Choices Bank is a free service that makes your *My Choices* form available anytime, anywhere, but only to health care providers and those you choose. Doctors and family often cannot find advance directives when they are needed most. You can prevent confusion and an unnecessary burden on those you love by depositing your advance directive in the Choices Bank. The process is easy and only takes a few minutes. Go to [www.choicesbank.org](http://www.choicesbank.org) or call (406) 329-2707 for details.

The Choices Bank uses a secure Web site and the same encryption technology used by financial banks to protect your privacy while making your advance directive available only to you, health care providers, and those you choose. You will see your advance directive exactly as you signed it. You may also print it, but not change it in any way. When you want to revise it, deposit a new advance directive.

After your deposit, you will receive a Depositor Kit with two wallet cards. Carry one in your wallet next to your driver's license or health card. Give the other to the person you named as your Representative. Share this information with your other loved ones and your doctor.

*My Choices* was created by the Advance Care Planning Task Force of the Life's End Institute: Missoula Demonstration Project to offer a standard advance directive form for use throughout Montana.

## Getting More Assistance

*To learn more about completing an advance directive, contact any of the following.*

- **Choices Bank**  
PO Box 8485, Missoula, MT 59807  
(406) 329-2707  
[www.choicesbank.org](http://www.choicesbank.org)  
A free service that makes advance directive forms available anytime, anywhere. Provides free My Choices forms, booklets, and information.
- **Missoula Aging Services**  
337 Stephens, Missoula, MT 59801  
(406) 728-7682 or (800) 551-3191  
[www.missoulaagingservices.org](http://www.missoulaagingservices.org)  
Provides basic consultation, materials, attorney referrals, and a free notary service.
- **Community Medical Center**  
2827 Fort Missoula Rd., Missoula, MT 59804  
(406) 327-4063, 327-4064 or 327-4059  
[www.communitymed.org](http://www.communitymed.org)  
Provides My Choices advance directive forms, information, and advice.
- **St. Patrick Hospital and Health Sciences Center**  
500 West Broadway  
PO Box 4587, Missoula, MT 59806  
(406) 329-5802, 329-5789 or 329-2675  
[www.saintpatrick.org](http://www.saintpatrick.org)  
Provides My Choices advance directive forms, information, and advice.
- **State Bar of Montana**  
Lawyer Referral Service  
(406) 449-6577  
[www.montanabar.org](http://www.montanabar.org)  
Provides names of local lawyers who can advise you.
- **Life's End Institute:  
Missoula Demonstration Project**  
320 E. Main St., Missoula, MT 59802  
(406) 728-1613  
[www.lifes-end.org](http://www.lifes-end.org)  
Provides resources, referrals, and a free lending library.
- **Partnership for Caring:  
America's Voices for the Dying**  
1620 Eye Street NW, Suite 202, Washington, DC 20007  
(202) 296-8071, Hotline: (800) 989-9455  
[www.partnershipforcaring.org](http://www.partnershipforcaring.org)  
Provides information and state-specific forms on its Web site.

### CHOICES BANK

PO Box 8485 • Missoula, Montana • 59807

[www.choicesbank.org](http://www.choicesbank.org)