



# ADVANCE DIRECTIVES

## *Your Life, Your Plan.*

Completing the Advance Directive form is optional. If you decide to make an advance directive, be sure to talk about it with those close to you. The conversation is just as important as the document. Give copies to family members or friends, your doctors, and your local hospital.

Adults can decide for themselves whether or not they want medical treatment. This right to decide applies to treatments that can extend life, like a breathing machine or a feeding tube. Tragedy, accident, or illness can take away a person's ability to make healthcare decisions, but decisions still have to be made. If you cannot do so, someone else will, and they may not know your values and priorities.

The advance directive is meant to reflect your preferences. You may complete all of it or only part, and it will still be considered a valid document. You are not required by law to use this specific form. Different forms, including electronic and video versions of the advance directive, are available online.

### ***Part I of the Advance Directive: Selection of Healthcare Agent***

An advance directive can be used to name a healthcare agent. This is someone you trust to make healthcare decisions for you. Your healthcare agent should be someone who can be easily reached and who would respect your wishes in an emergency situation. You can name anyone you want to be your healthcare agent. To name a healthcare agent, use Part I of the advance directive form (some people refer to this kind of advance directive as a "durable power of attorney for healthcare or medical power of attorney"). Your agent will speak for you and make decisions based on what you would want done or your best interests. You decide how much power your agent will have to make healthcare decisions. You can also decide when you want your agent to have this power—right away, or only after two doctors say that you are not able to decide for yourself.

*Part I of the Advance Directive: Selection of Healthcare Agent (CONTINUED)*

Remember, your agent will have the power to make important treatment decisions, even if other people close to you might urge a different decision. Also, consider picking a back-up agent, in case your first choice isn't available when needed. Be sure to inform your chosen agents and make sure that they understand what's most important to you.

***Part II of the Advance Directive: Treatment Preferences ("Living Will")***

You have the right to use an advance directive to say what you want about future medical treatment issues. You can do this in Part II of the form. Part II lets you decide about life-sustaining procedures in three situations:

1. When death from a terminal condition is imminent (going to occur soon) despite the application of life-sustaining procedures (like intubation or CPR).
2. A condition of permanent unconsciousness called a persistent vegetative state.
3. An end-stage condition, which is an advanced, progressive, and incurable condition resulting in the inability to care for yourself. One example of an end-stage condition could be advanced Alzheimer's disease.

Patient Label

## Maryland Advance Directive: Planning for Future Healthcare Decisions

BY: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
PRINT NAME MONTH DAY YEAR

### PART I: SELECTION OF HEALTHCARE AGENT

#### A. Selection of Primary Agent

I select the following individual as my primary agent to make healthcare decisions for me:

\_\_\_\_\_

FULL NAME, ADDRESS, AND TELEPHONE NUMBER(S) OF AGENT

#### B. Selection of Back-up Agents *(Optional: Cross through section if you do not wish to complete)*

If my primary agent cannot be contacted in time or for any reason is unavailable or unable or unwilling to act as my agent, then I select the following person to act in this capacity:

\_\_\_\_\_

FULL NAME, ADDRESS, AND TELEPHONE NUMBER(S) OF AGENT

#### C. Powers and Rights of Healthcare Agent

My agent will have full power to make healthcare decisions for me, including the ability to:

- Consent or not to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, like ventilators and feeding tubes.
- Decide who my doctor and other healthcare providers should be.
- Decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility, or hospice program.
- Ride with me in an ambulance if ever I need to be rushed to the hospital and be able to visit me if I am in a hospital or any other healthcare facility.

#### Access to My Health Information—Federal Privacy Law (HIPAA) Authorization

If, prior to the time the person selected as my agent has power to act under this document, my doctor wants to discuss with that person my capacity to make my own healthcare decisions, I authorize my doctor to disclose protected health information which relates to that issue.

Once my agent has full power to act under this document, my agent may request, receive, and review any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and other protected health information, and consent to disclosure of this information.



Frederick Memorial Hospital  
Frederick, MD 21701  
240-566-3300  
**ADVANCE DIRECTIVE**

Patient Label

For all purposes related to this document, my agent is my personal representative under the Health Insurance Portability and Accountability Act (HIPAA). My agent may sign, as my personal representative, any release forms or other HIPAA-related materials.

**THIS ADVANCE DIRECTIVE DOES NOT MAKE MY AGENT RESPONSIBLE FOR ANY OF THE COSTS OF MY CARE.**

My agent's powers are subject to the following conditions or limitations (*Optional: Cross through section if you do not wish to complete*):

**D. People My Healthcare Agent Might Consider Talking To** (*Optional: Cross through section if you do not wish to complete*):

In making important decisions on my behalf, I encourage my agent to talk with the following people. By filling this in, I do not intend to limit the number of people with whom my agent might want to talk to or my agent's power to make decisions.

**E. Effectiveness of this Part** (*Read both of these statements carefully, then initial one only*):

My agent's power is in effect:

Immediately after I sign this document, subject to my right to make any decision about my healthcare if I want and am able to.

**OR**

Only after my attending doctor and a second doctor determine that I am not capable of making an informed decision regarding my healthcare.

**You may stop here, if you only wish to identify a Healthcare Agent.  
The final signature page must still be completed.**

**PART II: TREATMENT PREFERENCES ("LIVING WILL")**

**A. Statement of Goals and Values** (*Optional: Cross through section if you do not wish to complete*):

I want to say something about my goals and values, and especially what's most important to me during the last part of my life. Where might I prefer to be? Who I might I want to be with? When might it be ok to limit aggressive treatment?

**B. In Case of Pregnancy** (*Optional, for women of child-bearing years only; form valid if left blank. Cross through section if you do not wish to complete*) If I am pregnant, my agent shall follow these specific instructions:



Frederick Memorial Hospital  
Frederick, MD 21701  
240-566-3300  
**ADVANCE DIRECTIVE**

Patient Label

**C. Preference in Case of Terminal Condition** (If you want to state what your preference is, *initial one only*. If you do not want to state a preference here, cross through the whole section) If my doctors certify that my death from a terminal condition is imminent (soon), even if life-sustaining procedures are used:

\_\_\_\_ Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

**OR**

\_\_\_\_ Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

**OR**

\_\_\_\_ Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

**D. Preference in Case of Persistent Vegetative State** (If you want to state what your preference is, *initial one only*. If you do not want to state a preference here, cross through the whole section) If my doctors certify that I am in a persistent vegetative state, that is, if I am not conscious and am not aware of myself or my environment or able to interact with others, and there is no reasonable expectation that I will ever regain consciousness:

\_\_\_\_ Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

**OR**

\_\_\_\_ Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

**OR**

\_\_\_\_ Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.

**E. Preference in Case of End-Stage Condition** (If you want to state what your preference is, *initial one only*. If you do not want to state a preference here, cross through the whole section): If my doctors certify that I am in an end-stage condition, that is, an incurable condition that will continue in its course until death and that has already resulted in loss of capacity and complete physical dependency:

\_\_\_\_ Keep me comfortable and allow natural death to occur. I do not want any medical interventions used to try to extend my life. I do not want to receive nutrition and fluids by tube or other medical means.

**OR**

\_\_\_\_ Keep me comfortable and allow natural death to occur. I do not want medical interventions used to try to extend my life. If I am unable to take enough nourishment by mouth, however, I want to receive nutrition and fluids by tube or other medical means.

**OR**

\_\_\_\_ Try to extend my life for as long as possible, using all available interventions that in reasonable medical judgment would prevent or delay my death. If I am unable to take enough nourishment by mouth, I want to receive nutrition and fluids by tube or other medical means.



Frederick Memorial Hospital  
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240-566-3300  
**ADVANCE DIRECTIVE**

Patient Label

**F. Additional OPTIONAL Statement on Life-Prolonging Treatments** *(Cross through section if you do not wish to complete)*

\_\_\_\_ If I am unable to make my own medical decisions and my doctors are reasonably certain that I will no longer be able to:

(SOMETHING THAT MEANS A LOT TO YOU. E.G. EATING, TALKING WITH GRANDCHILDREN)

then I would not want my healthcare agent(s) or loved ones to pursue aggressive, life-prolonging medical treatments such as feeding tubes, intubation, or CPR. If these treatments have already been started, I would want them stopped.

**G. Pain Relief**

No matter what my condition, give me the medicine or other treatment I need to relieve pain.

**H. Effect of Stated Preferences** *(Read both of these statements carefully, then initial one only):*

\_\_\_\_ I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to be a guide to whomever is making decisions on my behalf and my healthcare providers, but I authorize them to be flexible in applying these statements if they feel that doing so would be in my best interest.

**OR**

\_\_\_\_ I realize I cannot foresee everything that might happen after I can no longer decide for myself. Still, I want whoever is making decisions on my behalf and my healthcare providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

**PART III: SIGNATURE AND WITNESSES**

By signing below as the Declarant, I indicate that I am emotionally and mentally competent to make this advance directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance directive I may have completed before this date.



\_\_\_\_\_  
SIGNATURE OF DECLARANT

\_\_\_\_\_  
DATE

The Declarant signed or acknowledged signing the foregoing document in my presence and, based upon personal observation, appears to be emotionally and mentally competent to make this donation.



\_\_\_\_\_  
SIGNATURE OF WITNESS #1

\_\_\_\_\_  
DATE WITNESS #1 CONTACT INFORMATION



\_\_\_\_\_  
SIGNATURE OF WITNESS #2

\_\_\_\_\_  
DATE WITNESS #2 CONTACT INFORMATION

*Anyone chosen as a healthcare agent in Part 1 may not be a witness. Also, at least one witness must be someone who will not knowingly inherit anything from the Declarant or otherwise knowingly gain a financial benefit from the Declarant's death. Maryland law requires two witnesses but does not require this document to be notarized.*



## ***Frequently Asked Questions about Advance Directives in Maryland***

### ***Do the forms have to be notarized?***

No, but if you travel frequently to another state, you may wish to check to see if that state requires notarization.

### ***Do any of these documents deal with financial matters?***

No. If you want to plan for how financial matters can be handled if you lose capacity or pass away, please seek the guidance of your lawyer.

### ***When using these forms to make a decision, how do I show the choices that I have made?***

Write your initials next to the statement that says what you want. Don't use checkmarks or X's. You can also draw lines all the way through any statements that you do not want to complete.

### ***Are these forms valid in another state?***

It depends on the law of the other state. Most state laws recognize advance directives made somewhere else.

### ***Can my healthcare agent or my family decide treatment issues differently from what I wrote?***

It depends on how much flexibility you want to give. Some people want to give their agent flexibility in applying the living will. Other people want it followed very strictly. Say what you want in Part II, Paragraph H.

### ***Is an advance directive the same as a "Patient's Plan of Care", "Instructions on Current Life-Sustaining Treatment Options" form, or Medical Orders for Life-Sustaining Treatment (MOLST) form?***

No. These are forms used in healthcare facilities to document discussions about current life-sustaining treatment issues. These forms are not meant for use as anyone's advance directive. Instead, they are medical records, to be completed only when a doctor or other healthcare professional presents and discusses the issues. A MOLST form contains medical orders regarding life-sustaining treatments relating to a patient's medical condition and is completed by the doctor.

Frequently Asked Questions continue on the next page.



## *Frequently Asked Questions about Advance Directives in Maryland (CONTINUED)*

### ***Can my doctor override my living will?***

Usually, no. However, a doctor is not required to provide a medical treatment they do not feel will be effective even if a living will or agent ask for it.

### ***If I have an advance directive, do I also need a MOLST (Medical Order for Life-Sustaining Treatment) form?***

Yes. The MOLST form contains medical orders that will help ensure that all healthcare providers are aware of your wishes for care received right now. If you don't ever want emergency medical services personnel to try to resuscitate you in the event of cardiac or respiratory arrest, you must have a MOLST form. This is an order that must be signed by any of your doctors, Nurse Practitioners, or Physician Assistants. Your signature on this form is not necessary. If you are interested in completing a MOLST, please contact your doctor directly.

### ***What about donating my body for medical education or research?***

The State Anatomy Board has a specific donation program, with a pre-registration form available. You can call the Anatomy Board at 1-800-879-2728 for that form and additional information. You may also reach out to the FMH Advance Care Planning Social Worker for more information at 240-651-4541.

### ***If I appoint a healthcare agent and the healthcare agent and any back-up agent dies or otherwise is unavailable, a surrogate decision maker may need to be consulted to make the same treatment decisions that my healthcare agent would have made. Is the surrogate decision maker required to follow my instructions given in the advance directive?***

Yes, the surrogate decision maker is required to make treatment decisions based on your known wishes. An advance directive that contains clear instructions regarding treatment options is the best way to make your wishes known and therefore must be honored by the surrogate decision maker.