Honoring Choices®
FLORIDA

Welcome to Honoring Choices® Florida.

We are a comprehensive advance care planning program of Community Hospice & Palliative Care® and developed this document in collaboration with hospitals in north Florida. You can choose to complete your document electronically and we offer some information below to help get you started. Or if you would like free assistance with your advance care planning, we have trained facilitators and you can contact us **here** to schedule an appointment.

This document serves as a Designation of Healthcare Surrogate and a Living Will. When completed, you have the opportunity to save it electronically and/or print. It will NOT be saved by Honoring Choices Florida and we will not have access to your document so we cannot retrieve it for you at any time.

Below are some general guidelines to consider when completing your document electronically:

1. If you would like to review directions for each page, click **here** to see the entire document and guidelines for completion.
2. **When completing the document electronically, use the "tab" button (not "enter") to advance to the fillable sections or place the curser in each section to make your choices.** Complete all fillable sections and do not leave any section unanswered.
3. Most hospitals require all signatures to be "wet," meaning you and your witnesses must sign using blue or black ink. You MUST at least print the legal authority page (signature page) and then sign in front of two witnesses who will also sign. Your surrogates cannot witness and one witness must be someone other than your spouse and a blood relative.
4. We suggest you print all pages of your document and once signed, scan as a complete document to your computer to save it. You can then send it electronically as you choose.
5. Print single sided on 8 ½ x 11 size paper.
6. The spaces labeled Bar Code and Patient Label at the bottom of each numbered page are for your health providers' use. You do not need to do anything in those areas.
7. Make sure to give copies of your plan to your surrogates, family members and health providers. Have a conversation with them so they know what you want and will support your decisions.

If you have questions or would like assistance with your advance care planning, you can **contact us** or call **904.407.7024**.

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PART 1: MY HEALTH CARE DIRECTIVE

I have created this document with much thought to indicate my treatment choices and personal preferences, if I cannot communicate my wishes or am unable to make my own health care decisions. Any document created before this is no longer legal or valid. I understand that I need to complete a separate document if I want my surrogate to have authority to make decisions for me related to electroshock or psychosurgery, sterilization, pregnancy termination and/or experimental treatments.

My name: _____ **My date of birth:** _____

My address: _____

Telephone numbers (Primary): _____ **(Secondary):** _____

PART 2: HEALTH CARE SURROGATE DESIGNATION

If I am unable to communicate my wishes and health care decisions, or if my physician has determined that I am unable to make my own health care decisions, I choose the person(s) named on page 2 of 5 to express my wishes and make my health care decisions. My surrogate may:

- Access my health information and talk with my health care providers.
- Authorize treatment or have it withheld or withdrawn based on my wishes.
- Authorize release of my health information to appropriate health care providers.
- Authorize admission, discharge or transfer to care facilities.
- Make decisions about organ and tissue donations based on my wishes.
- Apply for benefits on my behalf.

My health care surrogate's authority becomes effective when my physician determines that I am unable to make my own decisions ***unless*** I indicate differently below.

Choose Your Option my health care surrogate's authority to receive my health information to take effect immediately.

Choose Your Option my health care surrogate's authority to make health care decisions for me to take effect immediately. Any decisions I make while I have capacity will supersede any instructions or decisions made by my surrogate that are in conflict with those made by me.

Barcode:

Hospital Label

I understand that my health care surrogate must be at least 18 years of age and cannot be a health care provider or employee of a health care provider giving direct care to me unless I am related to that person by blood or marriage, domestic partnership or adoption.

MY PRIMARY (MAIN) HEALTH CARE SURROGATE

Name: _____ **Relationship:**_____

Telephone numbers: (Primary) _____ **(Secondary)** _____

Address:_____

If I cancel my primary surrogate's authority, or if they are not willing, able or reasonably available to make a health care decision for me, I name as my first alternate surrogate:

1ST ALTERNATE HEALTH CARE SURROGATE

Name: _____ **Relationship:**_____

Telephone numbers: (Primary) _____ **(Secondary)** _____

Address:_____

If I cancel my primary and first alternate surrogates' authority, or if they are not willing, able or reasonably available to make a health care decision for me, I name as my second alternate surrogate:

2ND ALTERNATE HEALTH CARE SURROGATE

Name: _____ **Relationship:**_____

Telephone numbers: (Primary) _____ **(Secondary)** _____

Address:_____

If I have chosen my legal spouse as my primary or alternate surrogate, I want this person to continue as my surrogate if dissolution, annulment or termination of our marriage is in process or has been completed.

Choose Your Option

Barcode:

Hospital Label

PART 3: LIVING WILL AND HEALTH CARE INSTRUCTIONS

I understand that my preferences indicated below will apply **ONLY** if I become unable to communicate or make my own decisions **AND** if two physicians have determined that I have at least one of the following medical conditions:

Choose Your Option my wishes honored if I have a **TERMINAL CONDITION** (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).

Choose Your Option my wishes honored if I have an **END-STAGE CONDITION** (an irreversible condition that is caused by injury, disease or illness that has resulted in progressively severe and permanent deterioration and for which, to a reasonable degree of medical probability, treatment of the condition would be ineffective).

Choose Your Option my wishes honored if I am in a **PERSISTENT VEGETATIVE STATE** (permanent and irreversible condition of unconsciousness in which there is the absence of voluntary action or cognitive behavior of any kind and an inability to communicate or interact purposefully with the environment).

My wishes and preferences for my health care are noted below and I want my surrogate and health care providers to follow these choices **if I cannot speak for myself AND if I have one of the above conditions.**

Care Preferences	Check Your Choice Below
Cardiopulmonary Resuscitation (CPR)	**Choose Your Option**
Respirator / Ventilator (Breathing Tube)	**Choose Your Option**
Tube Feedings	**Choose Your Option**
IV Hydration	**Choose Your Option**
Dialysis	**Choose Your Option**
Hospice and Palliative Care	**Choose Your Option**

ORGAN/TISSUE DONATION

Choose Your Option to donate my eyes, tissues and/or organs, if able.

If I have specific instructions, I have written them in part 4 on page 4.

There may be situations in which my treatment preferences may not be followed, based on Florida law and/or a provider's mission or policies, and my surrogate or I may request a transfer to another provider.

Barcode:

Hospital Label

PART 4: COMMENTS AND ADDITIONAL INSTRUCTIONS (OPTIONAL)

I have written the following specific instructions and ask my surrogate, family members and health care providers to follow my wishes. If none, simply type **NA** to void this section.

Barcode:

Hospital Label

PART 5: LEGAL AUTHORITY

I have made this document willingly, I am thinking clearly and this document expresses my decisions about my future health care treatment:

Signature	Print Name	Date	Time

Witness 1 Signature	Print Name	Date	Time

Address	Phone

Witness 2 Signature	Print Name	Date	Time

Address	Phone

Your health care surrogate(s) cannot serve as a witness to this document. At least one witness must be someone other than your spouse or blood relative.

Barcode:

Hospital Label

This page is for your records only and is not a part of your advance care plan.

In addition to your health surrogate and alternate health surrogates, identify where copies of this advance health directive will be stored and with whom:

DOCTORS

Name:_____ Contact Info:_____

Name:_____ Contact Info:_____

Name:_____ Contact Info:_____

HOSPITALS

Name:_____ Contact Info:_____

Name:_____ Contact Info:_____

OTHERS (SUCH AS FAMILY MEMBERS, FRIENDS, CLERGY)

Name:_____ Contact Info:_____

Name:_____ Contact Info:_____

Name:_____ Contact Info:_____

NEXT STEPS FOLLOWING COMPLETION OF DOCUMENT

Now that you have completed your health care directive, you should also take the following steps:

Talk to the person you name as your health care surrogate, if you haven't already done so. Make sure your surrogate feels that he/she is able to perform this important job for you in the future.

Talk to the rest of your family and close friends who might be involved if you have a serious illness or injury. Make sure they know who your health care surrogate is and what your wishes are.

Make sure your wishes are understood and will be followed by your doctor and other medical providers.

Keep a copy of your health care directive where it can be easily found.

If you go to a hospital or nursing home, take a copy of your health care directive and ask that it be placed in your medical record.

Review your health care wishes every time you have a physical exam or whenever any of the *Five Ds* occur:

Decade:	When you start each new decade of your life.
Death:	Whenever you experience the death of a loved one.
Divorce:	When you experience a divorce or other major family change.
Diagnosis:	When you are diagnosed with a serious health condition.
Decline:	When you experience a significant decline or deterioration of an existing health condition, especially when you are unable to live on your own.