Health Care Directives

Completion of this form is optional

Name: _____

Address _____

City _____

Province _____ **Postal Code**_____

Provincial Health #_____

To my family, my friends, my physicians, and all others to whom it may concern:
It is my intention that this directive be respected by my physician, my family, and my friends, when I am no longer capable of consenting to health care on my own behalf.

I am aware that this directive will apply when I am no longer able to speak for myself. I have signed this document and expect health care providers to use the information to direct my care.

Please read carefully, as there are three separate situations.

I understand that the health care team will meet with my appointed proxy(s) or substitute health care decision maker to discuss my prognosis, available interventions, and its benefit in my circumstances.

Please place a copy of this Health Care Directive on my health record.

****It is ILLEGAL to sign or make a health care directive or appoint a proxy for another person****

I, _____, voluntarily make this directive concerning my health care.

_____ _____
Client Signature **Date**

_____ _____
Witness **Date**

Please notify your physician / care providers of the existence of your Directive and give them either this original or a copy to be placed on your health record. If you change or revoke your Directive you MUST inform your physician / care providers and replace with a current document.

Appointment of a Health Care Proxy

Completion of this form is optional

The purpose of this Appointment is to designate the Health Care Proxy [also known as Substitute Health Care Decision Maker (SHCDM)]

for _____
(Please Print Client's Name)

Provincial Health # _____

Health Care Proxy [Substitute Health Care Decision-Maker(s)] Appointment

I hereby appoint the following person(s) to be my Health Care Proxy. This person or persons will have the authority to make health care decisions on my behalf **when I lack the ability or capacity to make them for myself**.

(Please print)

Health Care Proxy Name: _____

Address: _____

_____

Phone #: _____
(or other contact information – i.e. cell phone, e-mail, etc.)

Health Care Proxy Name: _____

Address: _____

_____

Phone # : _____
(or other contact information – i.e. cell phone, e-mail, etc.)

I have named more than one Health Care Proxy, I wish them to act: (*check your choice):*

☐ In the order which they were listed (i.e. individually and in succession) **OR** ☐ Together

Client's Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

This is a legal document and will remain valid until changed or destroyed by the client making the above appointment. **It is illegal to sign or make a health care directive or appoint a proxy for another person** as per *The Health Care Directives and Substitute Health Care Decision Makers Act (1998, 2017).*

Situation A:

I have been, or may be, diagnosed with an illness from which I am likely to recover.
The following are my wishes:

Instructions:

The box below lists some interventions upon which you may wish to comment. Please indicate your wishes by placing your initials in the box for the interventions you would accept or not accept under Situation A.

Health Care Directive **Intervention**	**Yes,** **I would accept**	**No,** **I would not accept**
I would be willing to accept all life supporting machines and treatments as needed while there is a chance of recovering.		
If your answer to the above question is "No, I would not accept", please initial below which interventions you would or would not accept.		
Cardiopulmonary Resuscitation (CPR) - this might include chest compressions, electric shocks and intubation (artificial breathing) in an attempt to restart the heart.		
A feeding tube inserted from the nose into the stomach.		
Transfer to a tertiary (larger provincial) hospital.		
A machine to help me breathe (mechanical ventilation in a tertiary hospital).		
A feeding tube surgically inserted directly into the stomach (tertiary hospital).		
Other:		
Other:		

Situation B:

The following are my wishes if:

1. **I (may) suffer from an illness that may require many months or even years to recover. During that time, life support may be required to ensure the continuation of my life; *or***
2. **I have (mild, moderate or severe) dementia.**

Instructions:

The box below lists some interventions upon which you may wish to comment. Please indicate your wishes by placing your initials in the box for the interventions you would accept or not accept under Situation B

Health Care Directive **Intervention**	**Yes,** **I would accept**	**No,** **I would not accept**
I would be willing to accept all life supporting machines and treatments as needed while there is a chance of recovering.		
If your answer to the above question is "No, I would not accept", please initial below which interventions you would or would not accept.		
Cardiopulmonary Resuscitation (CPR) - this might include chest compressions, electric shocks and intubation (artificial breathing) in an attempt to restart the heart.		
A feeding tube inserted from the nose into the stomach.		
Transfer to a tertiary (larger provincial) hospital.		
A machine to help me breathe (mechanical ventilation in a tertiary hospital).		
A feeding tube surgically inserted directly into the stomach (tertiary hospital).		
Other:		
Other:		

Situation C:

The following are my wishes if:

1. **There is no expectation of my recovery; *or***
2. **I have (mild, moderate or severe) dementia; *or***
3. **My death is inevitable and I would only be alive on life support.**

Instructions:

The box below lists some interventions upon which you may wish to comment. Please indicate your wishes by placing your initials in the box for the interventions you would accept or not accept under Situation C

Health Care Directive **Intervention**	**Yes,** **I would accept**	**No,** **I would not accept**
I would be willing to accept all life supporting machines and treatments as needed while there is a chance of recovering.		
If your answer to the above question is "No, I would not accept", please initial below which interventions you would or would not accept.		
Cardiopulmonary Resuscitation (CPR) - this might include chest compressions, electric shocks and intubation (artificial breathing) in an attempt to restart the heart.		
A feeding tube inserted from the nose into the stomach.		
Transfer to a tertiary (larger provincial) hospital.		
A machine to help me breathe (mechanical ventilation in a tertiary hospital).		
A feeding tube surgically inserted directly into the stomach (tertiary hospital).		
Other:		
Other:		

Further Wishes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signed and declared:
If you are physically **able** to, sign your name and date below.

Name	**Signature**	**Date**

If you are physically **unable** to sign, a person of your choice may complete this directive and sign on your behalf at your instruction. The signature of this person must be witnessed and the witness must sign below. A person appointed as a proxy or a proxy's spouse cannot sign as a witness or as the person signing on your behalf.

Name	**Signature of the person who is signing on my behalf**	**Date**

Name	**Witness**	**Date**

Please Note:
When making a health care directive, it is a good idea to make copies available to your proxy (s) or substitute decision maker, family members, your doctor, your Special Care Home care providers and any health care facility to which you are admitted. You may also place a copy on your refrigerator for ease of access in emergencies.