# advance care planning kit

*Conversations about end-of-life care*

## The GIFT Initiative of Alive

**G**ive peace of mind. **I**nform yourself. **F**ill out documents. **T**alk to your loved ones.

# the GIFT of conversation

**THE GIFT of planning and conversation is important.** You may think of Advance Care Planning as being about death and dying, but it is really about how you want to live in the time you have left. Discussing values, personal preferences, and end-of-life care can provide a shared understanding of what matters most.

*Studies show that when planning and conversations have taken place, people are more likely to have a peaceful death, and family members are less likely to suffer from prolonged grief and depression.*

**No one knows what the future holds, and we cannot control or predict our health.** We can plan ahead, share with our loved ones what really matters, and – when that time comes – help make the decisions easier.

## THIS KIT...

- helps keep end-of-life conversations **simple and stress-free**
- helps you **determine and communicate** your values and preferences
- contains **legal documents** to help you and your loved ones
- gives **peace of mind**

---

**When asked,** most people hope to spend the end of their lives at home, free of pain, with comfort and as much control and independence as possible, to be treated with dignity, compassion and respect, and to be with those they love. ***Without advance planning, this is not likely to happen.***

**NOTE: This kit provides general information, and is not intended to replace specific medical or legal advice.** No Advance Care Plan and no one conversation can include all the decisions you and your loved ones may face. *The GIFT Initiative's purpose is to make an end-of-life journey the best it can be – for you and your loved ones.*

***ATENCIÓN:*** *si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al* ***1-615-346-8610****.*

# what's inside



My patients inspired me to create an advance care plan. I want my family to know my wishes, and I want to have a say in my care, like my patients do.

**Ana Mosemiller, CHPNA,**
**Hospice Aide for Alive, Mother, and Grandmother**
*Nashville, TN*

# give *your loved ones peace of mind with an Advance Care Plan*

**We think our loved ones know what we want.** But studies show when we don't ***give*** them an Advance Care Plan, not only are our wishes often not met, but we create stress and confusion for our loved ones as they try to guess our values and desires.

## WHAT IS AN ADVANCE CARE PLAN (ACP)?

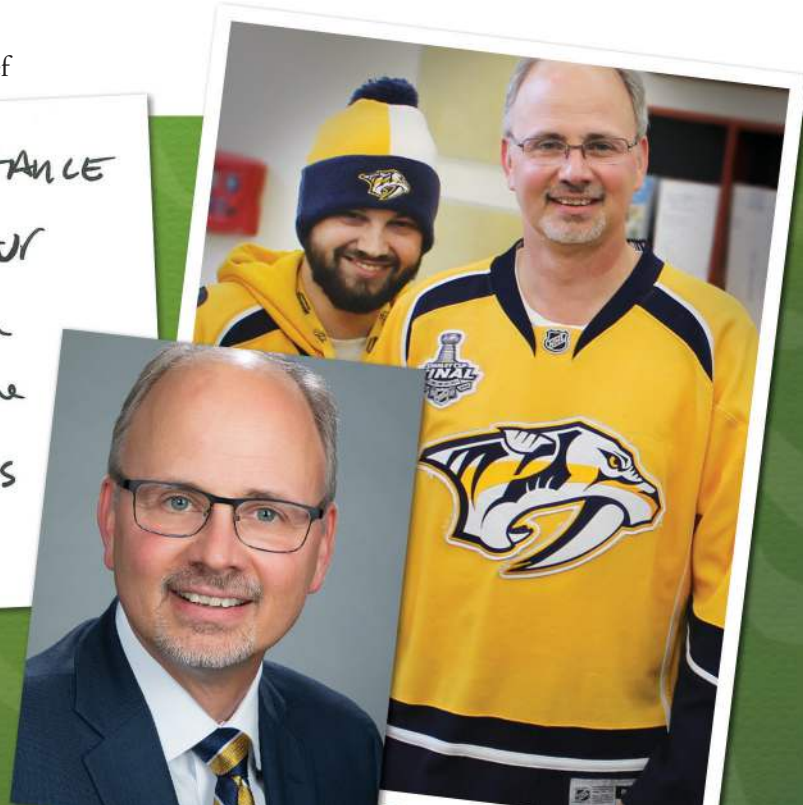
An **Advance Care Plan** is documentation about the kind of care you wish to receive should you become unable to speak for yourself, based on your personal values and preferences.

## WHY IS IT IMPORTANT?

*Studies show that Advance Care Plans:*

- Improve the quality of end-of-life health care
- Are likely to decrease hospital and intensive care stays and emergency room visits at the end of life
- Improve the end-of-life time for people and their loved ones by focusing on goals of care, values, and emotions rather than specific treatments
- Will increase the likelihood of dying in your own home or a location of your choosing
- Is most likely to prevent end-of-life care that is non-beneficial and contrary to people's wishes, which may turn the final weeks and months into a "medical treadmill"
- Lessen stress and disagreements during a medical crisis, and help eliminate misunderstandings or incorrect perceptions
- Encourage clear discussions which leave nothing important unsaid, avoiding regrets and anguish that can result from not having had such conversations
- Increase the likelihood that loved ones will cope better with grief

I know first hand the importance of having your i's dotted and your t's crossed. In my career as a financial Professional I have seen the problems that occur when the plans are not committed to paper.



**Joe Hampe, Chief Operating Officer at Alive,**
**Husband, Father, and Preds Super Fan,** *Nashville, TN*

## WHO SHOULD HAVE AN ADVANCE CARE PLAN?

*Everyone over 18 years of age – regardless of current health*

- Medical crises can happen any time. They may be upsetting and stressful, and you or your loved ones may be asked difficult questions.
- When wishes have been determined and also discussed, no one has to guess.
- Advance Care Plans are for everyone who wants to worry less about the future, and who wants to help their loved ones during a challenging time.

## WHO CAN SERVE AS YOUR VOICE?

*If you are so ill you cannot speak for yourself, who would you choose to speak for you? Do they know your care wishes, and what really matters to you?*

### They should:

1. know and understand your values, your wishes, and your fears;
2. be willing to handle stressful situations;
3. be able to tell doctors what type of care you prefer, and what you do not want.

> *When family members are tasked with making difficult decisions for dying patients they often experience stress, guilt, and regret when they aren't confident that they know what their loved one would want.*
>
> David Wendler and Annette Rid, "Systematic Review: The Effect on Surrogates of Making Treatment Decisions for Others," Annals of Internal Medicine 154, no. 5 (2011): 344, doi: 10.7326/0003-4819-154-5-201103010-00008.

# inform *yourself, decide what matters*

## THINK ABOUT *your values, your experiences, your wishes for end-of-life care.*

- What is important to have around you at the end of your life?
- What gives your life purpose every day?
- What is important to you in your relationships?
- How do your beliefs guide you?
- Have you accepted that your health might change in the future?
- How involved do you want to be in decisions?
- Do you value privacy or being surrounded by loved ones?

**Angélica Deaton,**
**Volunteer at Alive, wife, and mother,**
*Lebanon, TN*

As an attorney, wife, and mother, I understand the importance of having my wishes known in case of unexpected situations, not only for myself, but for my loved ones as well.

**THINK ABOUT IT AND BEGIN:** *Write down your thoughts on these pages to help your loved ones understand your care wishes.*

## YOUR VALUES

**Purpose:** Each day, what gives your life meaning? At the end of your life, what will matter most? Can you list the three most important things?

**1.** _____

**2.** _____

**3.** _____

**Relationships:** Each day it will be important to:

Spend time with loved ones, doing _____

Take care of others by _____

Spend time with my friends, such as _____

**Lifestyle:** What is important to me:

Hobbies or interests such as _____

Favorite foods such as _____

Helping others such as _____

To spend my time _____

I would like to have near me _____

Other _____

**Beliefs that guide your life:** What is important?

My daily ritual of _____

For others to _____

Beliefs that give me strength and help me face challenges are:

_____

_____

_____

Finally, during the last phase of my life, I want my loved ones to know:

_____

_____

_____

# YOUR EXPERIENCES

Are there life experiences you would like to share with loved ones before you die?

_____

_____

_____

Are there life experiences you would like to avoid discussing at the end of your life?

_____

_____

_____

# YOUR WISHES – *Physical, mental, emotional*

*On these scales, indicate how you feel to help your loved ones understand your care wishes.*

**Privacy:** When that time comes, I want to

| | |
|---|---|
| Be alone, and everyone does not need to know everything. | Be surrounded by loved ones, and they can know everything. |

**Information:** If I have a life-limiting condition, I want to

| | |
|---|---|
| Not know the details. The basics are fine. | Know exactly how long my doctors think I have to live. |

**Control:** I prefer to

| | |
|---|---|
| Trust my doctors with my medical decisions. | Be involved in every treatment decision. |

**Involvement:** I prefer

| | |
|---|---|
| For my loved ones to do exactly what I would want, even if they disagree. | Trusting my loved ones to make the decisions they feel are best. |

**Place:** I prefer to be

| | |
|---|---|
| In my own home, or a home-like location. | In a health care facility. |

**Treatment:** I prefer

| | |
|---|---|
| Less treatment. I prefer quality of life over quantity. | Everything possible to gain more time, no matter how uncomfortable. |

# YOUR CARE

*How important are these to you?* **Rank from 1 to 10:** 1 = not important at all, 10 = very important. This will help your loved ones understand your care wishes.

**Physical:** Accepting help or remaining independent.

_____ To be able to speak

_____ To be able to hear

_____ To take care of yourself: feeding, bathing, dressing

_____ To walk and move around by yourself

**Mental:** Fully aware or peace without awareness.

_____ To make your own decisions

_____ To be aware who or where you are

**Emotional:**

_____ To have meaning in each day of my life

_____ To feel the love of others, to spend time with them

_____ To give love or support to others

**Quality or Quantity:**

_____ To have the best ***quality*** of life possible

_____ To have the most ***quantity*** of life possible

# YOUR VOICE

*Choose a person you trust* *(called your "agent" on the Advance Care Plan forms, which establish power of attorney)* to express your wishes and make health care decisions for you if you cannot speak for yourself. You will also be asked to choose an alternate.

## Who do you choose to speak on your behalf? *(Name)*

☐ My spouse or partner _____

☐ My child or children _____

☐ My mom or dad _____

☐ My sister or brother _____

☐ My doctor _____

☐ My caregiver _____

☐ My friend _____

☐ Person who shares my beliefs _____

☐ Other _____

*Page 17 of this kit has a form with a place on it to add the names of those whom you have made aware of your Advance Care Plan wishes, including their contact information.*

# fill out documents

## PUT YOUR WISHES INTO A PLAN

*You have already begun! By thinking about and writing down your values and preferences.*

Along with having the conversation with your loved ones, review or complete the two forms enclosed in this section, or you may download and print blank forms at *AliveHospice.org/AdvanceCarePlan*.

1. Advance Care Plan *(Tennessee)*
2. Appointment of Health Care Agent *(power of attorney for the person and alternate you have chosen)*

**NOTE:** Both forms must either be witnessed *(by two competent adults)* or notarized.

* ***If applicable, fill out the POST form.*** *Information about this form is found on page 14. The POST form is found on page16.*

## REMEMBER

**No form, kit, or single conversation can include all the decisions you and your loved ones may face.**

Treatment decisions should be made after understanding your preferences, and then learning the risks, benefits, and expected outcomes.

- Treatments can be helpful if they offer cure, relieve suffering, restore functioning, or enhance quality of life.
- Treatments can be harmful if they cause pain or postpone dying without offering benefit.

***These decisions are personal.*** *It is always appropriate to stop a treatment that is no longer working and is only prolonging the dying process. Remember, it is the underlying disease or condition that causes death, not stopping the treatment.*

## LEARN ABOUT END-OF-LIFE ISSUES AND OPTIONS:

To help you fill out the Advance Care Plan forms, review Frequently Asked Questions, and learn more about treatment options, visit: *AliveHospice.org/AdvanceCarePlan*

**Tennessee Department of Health**
**Division of Health Licensure and Regulation**
**Office of Health Care Facilities**
**227 French Landing, Suite 501**
**Heritage Place Metrocenter**
**Nashville, TN 37243**
**Telephone (615) 741-7221**
**Fax (615) 253-8798**
**www.tn.gov/health**

# ADVANCE CARE PLAN
(Tennessee)

I, _____, 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 person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: (___)_____ Relation: _____
Address: _____

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Phone #: (___)_____ Relation: _____
Address: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

**When Effective** (mark one):

☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself.
☐ I do not give such permission (this form applies only when I no longer have capacity).

---

**Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

| | |
|---|---|
| ☐ Yes ☐ No | **Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma. |
| ☐ Yes ☐ No | **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. |
| ☐ Yes ☐ No | **Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help. |
| ☐ Yes ☐ No | **End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds 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 (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

| | |
|---|---|
| ☐ Yes ☐ 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. |
| ☐ Yes ☐ 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. |
| ☐ Yes ☐ 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. |
| ☐ Yes ☐ No | **Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration. |

**Please sign on page 2**

**Other instructions, such as burial arrangements, hospice care, etc.:** _____
_____
_____
_____
(Attach additional pages if necessary)

**Organ donation:** Upon my death, I wish to make the following anatomical gift (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____
_____

☐ No organ/tissue donation

## SIGNATURE

Your signature must **either** be witnessed by two competent adults **or** notarized. If witnessed, neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Signature: _____ DATE: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

This document may be notarized instead of witnessed:

**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.

Notary Public:_____
Signature

My commission expires:_____

## WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

**APPOINTMENT OF HEALTH CARE AGENT FOR _____**
**(TENNESSEE)** ***(print or type name of patient)***

If I become unable to make or communicate decisions for myself, it is up to my Health Care Agent to communicate my health care wishes and to see that my legal rights are protected. While there may be others who wish to be involved in my care, I want my Agent to have the final say on any & all health care decisions, including:

- ➢ Decisions to accept or to refuse any treatment, service or procedure used to diagnose or treat my condition;
- ➢ Decisions to provide, withhold or withdraw life-sustaining treatments, including artificially provided nutrition and hydration, &;
- ➢ Decisions regarding organ donation, burial arrangements, cremation, and autopsy.

I remind my Agent of the responsibility to honor any other advance directives that I've completed and to follow any additional instructions I have left. If my Primary Agent is either unavailable or unwilling to serve, I would like my Alternate Agent named below to make these health care decisions for me. (Note: you do not have to name an Alternate Agent.)

NOTE: If there are any decisions that you do **not** want your Health Care Agent to make for you, or if you have any additional instructions for your Health Care Agent, please list them on the back of this form.
☐ Check here if you have added additional instructions.

Primary Agent:

_____
Name (print)

_____
Address

_____
City State Zip Code

(_____) _____
Area Code Home Phone Number

(_____) _____
Area Code Work/Cell Phone Number

Alternate Agent (optional):

_____
Name (print)

_____
Address

_____
City State Zip Code

(_____) _____
Area Code Home Phone Number

(_____) _____
Area Code Work/Cell Phone Number

_____ / _____
**Patient's name (please print or type)** **Date**

_____ / _____
**Signature of patient** *(must be at least 18 or emancipated minor)* **Date**

**To be legally valid, you must complete either Block A or Block B below**

---

Block A Witnesses (TWO witnesses required)

1. I am a competent adult who is not named above. I witnessed the patient's signature on this form. Signature of witness number 1 **Date**

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his/her death. I witnessed the patient signature on this form. Signature of witness number 2 **Date**

---

Block B Notarization

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 whose name is shown above 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: _____

_____
Signature of Notary Public

# What is POST?

## Physician Orders for Scope of Treatment, or "POST"

*POST is a tool that gives seriously ill or frail patients more control over the types of healthcare treatments they receive toward the end-of-life.*

**The POST form is signed by both patient and physician,** Tennessee's POST form promotes communication between patients and their healthcare providers, enabling patients to make informed decisions that will help prevent unwanted treatment, reduce patient and family suffering, and help ensure that the patient's wishes are honored.

## WHY IS POST IMPORTANT?

**A completed POST form ensures that a patient's wishes become *actionable physician's orders* that are entered into the patient's medical record and adhered to by healthcare providers even if patients move from one care setting to another.**

**EXAMPLE:** This means that if a patient is moved, from home or a skilled nursing facility to a hospital, his POST moves with him to ensure that all of the healthcare providers involved - including any Emergency Medical Technicians *(EMT)* who transport him - will know his specific healthcare wishes, even if he is no longer able to communicate.

## HOW DOES A POST DIFFER FROM AN ADVANCE CARE PLAN?

**POST complements but does not replace an Advance Health Care Plan.** An Advance Care Plan allows adults of any age and health condition to appoint the person they would choose to speak for them if they were unable to speak for themselves. An Advance Care Plan also provides a broad outline of a person's healthcare priorities and wishes for care toward life's end. *However, an Advance Care Plan is not always available when needed, and does not carry the weight of a physician's orders.*

**POST, by contrast, is designed specifically for the seriously ill and/or frail, and specifies patient's wishes regarding key medical decisions.** POST constitutes actionable, enforceable medical orders that move with a patient from one care setting to another. In the absence of a POST form that provides medical orders to the contrary, in an emergency situation all medical treatments will be provided, including CPR, even if this is not what the patient would want.

| | ADVANCE CARE Plan | POST |
|---|---|---|
| **WHO** | Every Adult | Seriously Ill or Frail |
| **WHAT** | Broad Outline | Specific wishes and actionable physician's orders |
| **WHERE** | No universal location/must be retrieved | In medical record; Travels with patients |

# What is POST? *continued*

## CAN INSTRUCTIONS IN A POST FORM BE CHANGED?

**Completion of a POST form is always optional and form contents can be always be modified or revoked if patient preferences change for any reason.**

## WHAT IF COMPLETION OF A POST FORM IS RECOMMENDED BUT THE PATIENT IS INCAPACITATED?

**If the patient previously completed an Advance Care Plan and authorized a health care representative to make decisions on his behalf, then a POST form can be completed by that representative and the patient's physician.**

**If a representative was not previously authorized, then Tennessee law allows for the appointment of a surrogate to work with healthcare providers to complete a POST form.** While in addition to the patient or representative's signature, the form must be signed by the patient's physician; other members of the patient's care team such as nurses, social workers, or chaplains may also be involved to help ensure that the POST reflects the best possible understanding of what the patient would want, taking into consideration any physical, psychological, and spiritual issues.

**Directions for Health Care Professionals**

**Completing POST**

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

To be valid. POST must be signed by a physician or, at discharge or transfer from a hospital or long term care facility, by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Photocopies/faxes of signed POST forms are legal and valid.

**Using POST**

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the Health Care Agent or Surrogate of a person without capacity, can request alternative treatment.

**Reviewing POST**

This POST should be reviewed if:

(1) The patient is transferred from one care setting or care level to another, or
(2) There is a substantial change in the patient's health status, or
(3) The patient's treatment preferences change.

Draw line through sections A through D and write "VOID" in large letters if POST is replaced or becomes invalid.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

**TDH, Division of Health Licensure and Regulation, Office of Health Care Facilities, 665 Mainstream Drive, Second Floor, Nashville, TN 37243**

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

**Tennessee Physician Orders for Scope of Treatment (POST, sometime called "POLST)**

This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

Patient's Last Name

First Name/Middle Initial

Date of Birth

**Section A** *Check One Box Only*

**CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.**

☐ **Resuscitate (CPR)** ☐ **Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D.**

**Section B**

*Check One Box Only*

**MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.**

☐ **Comfort Measures.** Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. Treatment Plan: Maximize comfort through symptom management.**

☐ **Limited Additional Interventions.** In addition to care described in Comfort Measures Only above, use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer** to hospital if indicated. Generally avoid the intensive care unit. **Treatment Plan: basic medical treatment.**

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Additional Interventions above, use intubation, advanced airway interventions mechanical ventilation as indicated. **Transfer** to hospital and/or intensive care unit if indicated. **Treatment Plan: Full treatment including in the intensive care unit.**

*Other Instructions:*_____

**Section C**

*Check One*

**ARTIFICIALLY ADMINISTERED NUTRITION. Oral fluids & nutrition must be offered if feasible.**

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

*Other Instructions:*_____

**Section D**

*Must be Completed*

**Discussed with:**
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: _____(Specify)

**The Basis for These Orders Is:** (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical indications
☐ (Other) _____

| **Physician/NP/CNS/PA Name (Print)** | **Physician/NP/CNS/PA Signature** **Date** NP/CNS/PA (Signature at Discharge) | **MD/NP/CNS/PA Phone Number:** ( ) |
|---|---|---|

**Signature of Patient, Parent of Minor, or Guardian/Health Care Representative**

**Preferences have been expressed to a physician and /or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your surrogate.**

| Name (Print) | Signature | Relationship (write "self" if patient) |
|---|---|---|

| Agent/Surrogate | Relationship | Phone Number ( ) |
|---|---|---|

| Health Care Professional Preparing Form | Preparer Title | Phone Number ( ) | Date Prepared |
|---|---|---|---|

**TDH, Division of Health Licensure and Regulation, Office of Health Care Facilities, 665 Mainstream Drive, Second Floor, Nashville, TN 37243**

PH-4193 (Rev 7/15) RDA-10137

# talk to your loved ones

## TO PREPARE FOR THE CONVERSATION

**Who:** Choose who you want to talk to including your "agent," the person who you would like to be your voice. The conversation might include your parent(s), child or children, spouse or partner, sister or brother, friend, someone who shares your beliefs, a neighbor, or a caregiver.

**Where:** Choose the setting where you and others will feel most comfortable. It might be at your home, at a restaurant, in a park, or wherever seems best.

**When:** Choose the timing that works. For example, it might be:

- When prompted by a book, movie, or television program
- The next time you all come together
- While you are still feeling well
- Before or during a family milestone or holiday
- While estate planning

**How:** If it is difficult to begin, perhaps write a letter. Perhaps share a story you that will help to explain why this is important to you.

**What:** Good topics to cover are listed on page 3 and throughout the workbook section. *(Inform yourself, decide what matters, think about your values, your experiences, your wishes for end-of-life care.)*

*What's your inspiration for having an Advance Care Plan?*

## OTHER WAYS TO START

- "I want to be prepared for the future, and I need your help. Can we talk about it?"
- "I've been thinking about the last phase of my life, and I'd like to share my wishes with you. Would that be all right?"

**If you are beginning the conversation with a loved one or person in hopes of knowing what they want for the end of their life, direct statements and questions can help:**

- "If you ever got really sick, what type of care would you want, or not want?"
- "It worries me that we've never talked about it. I'd feel better if we did."
- "If you could choose, how would you want the time to be spent at the end of your life?"
- "What would you consider a good death?"

**Stay calm, go slowly, keep an open mind, be patient, and listen. Don't feel too much need to control the conversation. It may happen quite differently than you expect.**

- Be patient, give them time to understand, and give yourself time to appreciate their comments, questions, and opinions. Some people may need more time than others.
- Try not to judge. People can have very different views on end-of-life matters.
- It is valuable to merely try to talk, even if you don't succeed. The attempt will make it easier the next time.

## HAVE THE CONVERSATION

- Sharing your wishes can bring you closer to the people you love.
- Talking may reveal that you and your loved ones disagree, and that is alright. It is better to know this and talk now, rather than during a medical crisis.
- The conversation isn't a one-time thing; it can be the first of many.
- You will be better prepared for frank discussions with your doctor.
- What do you really want your loved ones to know matters to you?
- Conversations and planning provide a chance to address universal fears about death:
  - » Fear of pain and physical suffering;
  - » Fear of being lonely or dying alone;
  - » Fear of what will become of loved ones;
  - » Fear of being a burden;
  - » Fear of lacking peace of mind;
  - » Fear of the loss of control;
  - » Fear of the unknown, and death is the ultimate unknown.

## AFTER THE CONVERSATION

**When you have had the conversation(s) and completed the forms:**

- Give a copy of both forms to your doctor
- Keep copies where they are easily accessible to others, and let them know where to find your forms
- Give a copy of the forms to the person you have chosen as your voice and their alternate
- Review what is in the completed Advance Care Plan forms with your loved ones *(perhaps also your closest friends or neighbors)* so that they understand and it is familiar. It is common that during a medical emergency, they may need to respond from memory even though you have provided copies for them and your doctor.
- Try to keep phone numbers updated in your Advance Care Plan kit and wallet card *(which you can find on page 18 of this kit)*
- When your preferences change, let everyone know, including your doctor

## PERIODICALLY REVIEW YOUR PLAN

*Change it as needed, discuss it again.*

- After completing the steps in this kit, review it until you feel comfortable and are ready to talk to your loved ones.
- There are no right and wrong answers. Information can change, feelings can change, the people involved can change. You can change your mind and you can change your plan.
- Your goals may have changed since you last completed a Living Will or Advance Care Plan. Create a new one.
- After the conversation(s) give a copy of your Advance Care Plan to your loved ones and your doctor. An Advance Care Plan is valid anywhere and is not specific to any one state.
- Discussing it is as important as writing it down for when decisions must be made on your behalf during an emergency.
- You should also review your plan in the case of a change in your current health, a hospitalization, and other life changing events.

## REMEMBER

- Sharing your values and wishes with loved ones can help bring you closer.
- It is fine to disagree, and it is better for differences of opinion to be discovered now rather than during a medical emergency.
- It may be more than one conversation; you may want to have many.
- Besides talking to loved ones, you will become ready to have honest conversations with your doctor.

## LATER: REVIEW YOUR PLAN

*Change it as needed, discuss it again.*

# congratulations!

*You have given the **GIFT** of Advance Care Planning.*

You are helping move us toward a society in which everyone has their wishes respected at the end of their lives.

We hope you will share The Gift Initiative with family and friends.
For more information or feedback, please contact *info@alivehospice.org*

## I have shared my Advance Care Plan wishes with:

| NAME | RELATIONSHIP | PHONE | OTHER PHONE | DATE SHARED |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |



PHYSICIANS AS PATIENTS RARELY WANT HEROIC MEASURES. ALTHOUGH I HAVE EXPRESSED MY WISHES TO MY HUSBAND, HAVING AN ADVANCE CARE PLAN LIFTS THE BURDEN FROM HIM IN ADVANCE.

**Dr. Sasha Smith Bowers,**
**Alive Hospice Physician and Wife,** *Nashville, TN*

# learn more

## FREE EDUCATIONAL RESOURCES

**To understand more about hospice care:** *alivehospice.org/resources*

*Our educational resources include:*

- 10 Things That May Surprise You About Hospice Care
  *Includes the difference between palliative and hospice care*
- Information about hospice care and specific diagnoses
- Free legal docs for planned giving
- Legacy conversations and tools to help get you started
- Information about our grief support offerings
- And more!

**The GIFT Initiative** is a community education collaborative led by **Alive** with partners from **Vanderbilt University**, **Saint Thomas Health**, **Sarah Cannon Research Institute**, and others who recognize the need for better education about the benefits of planning in advance of life-limiting illnesses and end-of-life care.

The GIFT Initiative has developed education programs for delivery in small group settings. Program leaders include medical ethicists, doctors, nurses, social workers, chaplains, and lay leaders who live and work in our community and who have chosen to volunteer their time to help address, through education, the vital need for a shift in society in how the American culture deals *(or fails to deal)* with end-of-life issues.

**For more information, visit *AliveHospice.org/AdvanceCarePlan* or call 615-327-1085.**



### IN CASE OF EMERGENCY

My Name: _____

Emergency Contact: _____

Contact Phone: _____

My Address: _____

Doctor/Phone: _____

*I have completed an Advance Care Plan and provided my Doctor with a copy.*

### IN CASE OF EMERGENCY

My Name: _____

Emergency Contact: _____

Contact Phone: _____

My Address: _____

Doctor/Phone: _____

*I have completed an Advance Care Plan and provided my Doctor with a copy.*

### IN CASE OF EMERGENCY

My Name: _____

Emergency Contact: _____

Contact Phone: _____

My Address: _____

Doctor/Phone: _____

*I have completed an Advance Care Plan and provided my Doctor with a copy.*

### I have shared my Advance Care Plan wishes with:

Name: _____

Relationship/Phone: _____

Name: _____

Relationship/Phone: _____

the GIFT initiative
of alive hospice

**I have shared my Advance Care Plan wishes with:**

Name: _____

Relationship/Phone: _____

Name: _____

Relationship/Phone: _____

the GIFT initiative
*of alive hospice*

**I have shared my Advance Care Plan wishes with:**

Name: _____

Relationship/Phone: _____

Name: _____

Relationship/Phone: _____

the GIFT initiative
*of alive hospice*

## IMPORTANT NOTES

THE BEST GIFT I CAN GIVE MY DAUGHTER SOPHIA AND MY FAMILY IS TO TAKE AWAY ANY ADDITIONAL HARDSHIPS ABOUT "DECIDING" WHAT THEY THINK IS BEST FOR ME MEDICALLY AT THE END OF MY LIFE.

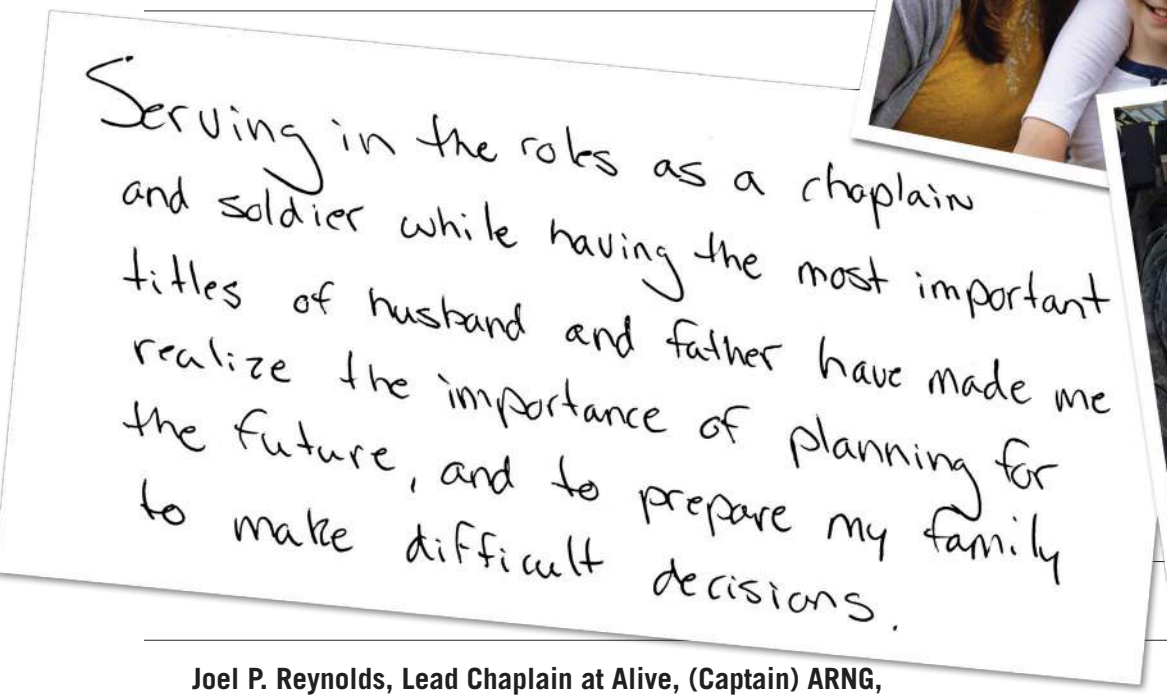
MAKING THIS DECISION IN ADVANCE IS ONE OF THE GREATEST GIFTS OF LOVE.

**Dr. Anh Meadows,**
**Alive Hospice Physician and Mother**
*Nashville, TN*

# notes

# notes

# notes




**Joel P. Reynolds, Lead Chaplain at Alive, (Captain) ARNG, Husband, and Father,** *Murfreesboro, TN*

# contact us

## Alive Offices

**MAIN OFFICE:** 1718 Patterson St., Nashville, TN 37203 | **Main Phone (24/7):** 615-327-1085

**FRANKLIN OFFICE:** 1897 General George Patton Drive, Suite 116, Franklin, TN 37067

**MURFREESBORO OFFICE:** 1629 Williams Drive, Murfreesboro, TN 37129

**HENDERSONVILLE OFFICE:** 230 New Shackle Island Road, Suite 150, Hendersonville, TN 37075

**LEBANON OFFICE:** 205 West High Street, Suite 102, Lebanon, TN 37087

## Dedicated Hospice Facilities

**Nashville Residence** *(30 beds)*
1710 Patterson St., Nashville, TN 37203 | 615-963-4800

**Murfreesboro Residence** *(10 beds)*
1629 Williams Drive, Murfreesboro, TN 37129 | 615-346-8356

**NOTE:** Over 90% of Alive Hospice's care is provided in private homes.

## Alive Grief Support

**Alive's Griefline:** 615-963-4732

Grief Counseling and Support available at our Nashville, Franklin, Hendersonville, Lebanon, and Murfreesboro Offices

## Follow Us

facebook.com/alivehospice
twitter.com/AliveHospice
linkedin.com/company/alive-hospice
youtube.com/alivehospice

Alive

*AliveHospice.org/AdvanceCarePlan*

We provide loving care to people with life-threatening illnesses, support to their families, and service to the community in a spirit of enriching lives.