# MY LIVING WILL
# AN ONTARIO ADVANCE DIRECTIVE

Study #________________

## Identification

Name: ____________________________________________ Alias, if any: __________________________

Mailing address: ________________________________________________________________________

_______________________________________________________________________________________

Phone: ______________________________________ Email: ______________________________________

Birth date (Day, Month, Year): ________________ Religion: ___________________________________

Name and contact information for family members you would want notified if you were seriously ill or dying.

_______________________________________________________________________________________

_______________________________________________________________________________________

Things which would help emergency and health care staff to identify me, i.e. scars, tattoos, body piercing, birthmarks, photo, or other identification (describe and provide its location):

_______________________________________________________________________________________

I __________________________________, understand this document allows me to do **one or both** of the
(full name)
following:

***Part 1 – Level of Care Directive****: Give health care and personal care instructions to guide others in making decisions for me in the event I cannot speak for myself. If I am in a situation where my wishes are relevant, my healthcare providers and any substitute decision makers I appoint must follow my wishes. In an emergency situation where healthcare providers are aware of my expressed wishes, my wishes must be followed.*

***Part II – Appointing a Substitute Decision Maker****: Name another person (called the substitute decision maker) to make health care decisions for me if I am unable to decide or to speak for myself. My substitute decision maker must make health care decisions for me based on the instructions I provide, the wishes I have made known to him or her, or act in my best interest if I have not made my wishes known.*

## Part I: Level of Care Directive

These are instructions for my health care when I am unable to decide or speak for myself and after I die. If I have appointed an agent, I want him/her to follow the instructions which reflect my preference below.

People who care for me could do the following to respect my dignity: ___________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

Other values that should influence my care in the event of serious injury or death: ________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

NAME: ______________________________

I am most proud of: ____________________________________________________________

________________________________________________________________________________

I would want to be remembered as a person who: _________________________________

________________________________________________________________________________

Current illnesses/health challenges that concern me: ____________________________

________________________________________________________________________________

My thoughts about how my medical condition might affect my family, friends or others: ___________________

________________________________________________________________________________

________________________________________________________________________________

People/agencies who should be notified in case of serious illness, injury or death: _______________________

________________________________________________________________________________

________________________________________________________________________________

________________________________________________________________________________

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE IF I AM SERIOUSLY ILL OR DYING AND UNABLE TO DECIDE FOR MYSELF. I KNOW I CAN CHANGE THESE CHOICES OR LEAVE ANY OF THEM BLANK.

The following part of the directive is the **Treatment Table**. For each of the health situations (found in the first column), imagine that you are in the situation described and require some life-sustaining treatment (found in the top row). If you do not receive this treatment, you would die. If you receive the treatment, the chance that you will live depends on the nature of the medical problem. Even if you recover fully from the medical problem, you would return to the health situation you were in before you developed the further medical problem.

For example, imagine that, at some future time, you suffer from a severe dementia. Then, you develop pneumonia requiring life-saving antibiotics. Without the antibiotics, you would die. With the antibiotics, your chance of surviving depends on the nature and severity of the pneumonia. Of course, even if the antibiotics were successful in treating your pneumonia, you would still have severe dementia. You should then decide whether or not you would want the particular treatment (antibiotics) if you were in this condition (severe dementia).

## COMPLETING THE TREATMENT TABLE

Write your treatment decision ("YES", "NO", "UNDECIDED," or "TRIAL") in the box for every combination of health situation and life-sustaining treatment. Take the example above. If in that situation you would want life-saving antibiotics, if they were the only hope of saving your life, you would write "YES" in the box found where the column "Antibiotics" and the row "Severe Dementia" meet. If you would not want antibiotics in those circumstances, write "NO" in that box. If you are undecided, you would write "UNDECIDED."

**NAME:** ______________________________

One other option is possible. In some cases, it may be unclear initially whether a given treatment will be beneficial or not. In these cases, you may want to try the treatment for an appropriate period, usually a few days to a couple of weeks. During this time your doctors would monitor and assess the effectiveness of the treatment and determine how beneficial it was for you. If the treatment proved to be beneficial, it could be continued. If not, it could be stopped. If you wish such a treatment trial, then write "TRIAL" in the box. For CPR and surgery, a treatment trial is not appropriate because these treatments are given all at once in a short time.

| | CPR | VENTILATOR | DIALYSIS | TUBE FEEDING | LIFE SAVING SURGERY | BLOOD TRANSFUSION | LIFE SAVING ANTIBIOTICS |
|---|---|---|---|---|---|---|---|
| CURRENT HEALTH | | | | | | | |
| MODERATE DEMENTIA[1] | | | | | | | |
| SEVERE DEMENTIA[2] | | | | | | | |
| PERMANENT COMA[3] | | | | | | | |

[1] *Moderate dementia* is a condition where a person is quite confused or forgetful. The person is moderately disabled and requires assistance for most activities of daily living throughout the day.
[2] *Severe dementia* is a condition where a person is extremely confused and has very limited awareness of his or her surroundings. The person is severely disabled and is completely dependent on others for total care.
[3] *Permanent coma* is a condition where a person is unconscious, and it is expected that the person will never regain consciousness. The person is completely dependent on others for total care.

These are my wishes about other personal care decisions, such as shelter, nutrition, hygiene, clothing and safety.

______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

These are my wishes about what I would want with my body if I die: ______________________________
______________________________________________________________________
______________________________________________________________________

ADDITIONAL CONCERNS: Other things which haven't been considered that are important for end of life care planning for me. If there are any particular persons who should *not* take part in decision-making for you, please record it here.

______________________________________________________________________
______________________________________________________________________

NAME: ______________________________

## Part II. Appointing a Substitute Decision Maker

☐ I do not want to name a substitute decision maker. Proceed directly to Part III on page 5.

SUBSTITUTE DECISION MAKER 1 – THE PERSON I WANT TO MAKE HEALTH CARE DECISIONS FOR ME

Name: ______________________________

Relationship to me: ______________________________

Address: ______________________________

Telephone: ______________________________

**If you want more than one person to be your substitute decision maker, add the additional names below:**

SUBSTITUTE DECISION MAKER 2

Name:______________________________

Relationship: ______________________________

Address: ______________________________

Telephone: ______________________________

SUBSTITUTE DECISION MAKER 3

Name: ______________________________

Relationship to me: ______________________________

Address: ______________________________

Telephone: ______________________________

1. Do you want proxies to make decisions individually (i.e. substitute decision maker 1 will make decisions if available, otherwise substitute decision maker 2 will make decisions etc.) or as a group?
   ☐ Individually ☐ As a group

2. If you want your proxies to make decisions as a group, how do you want disagreements to be resolved?
   ☐ Follow directions of substitute decision maker 1
   ☐ Follow directions of the majority of substitute decision makers

3. If I am unable to decide or speak for myself, my agent has the power to (check as many boxes as apply):

☐ Consent to (give permission), refuse, or withdraw any health care treatment, service, or procedure.
☐ Stop or not start medical interventions which are keeping or might keep me alive.
☐ Choose my health care providers.
☐ Obtain copies of my medical records and allow others to see them.
☐ Choose where I live when I need health care and what security measures are needed to keep me safe.
☐ Decide whether or not to donate my organs, tissues, and eyes, when I die.
☐ Decide what will happen with my body when I die.

**NAME:** ______________________________

4. List any additional powers or limits for my substitute decision maker(s):

_______________________________________________________________________________

_______________________________________________________________________________

## PART III: MAKING THE DOCUMENT LEGAL

I have read and understood all sections of this living will.

All previous living wills made by me are to be revoked, and this directive is to be followed.

The person(s) whom I have named as a substitute decision maker(s) is/are authorized to give directions and make decisions, on my behalf, concerning my personal care and to give or refuse consent on my behalf to treatment, in accordance with the instructions found in this living will.

If I have appointed at least one substitute decision maker, I intend that this living will shall be a Power of Attorney for Personal Care under the *Substitute Decisions Act*.

**MY SIGNATURE**: ________________________________________ Date signed: ___________________
(Sign your name here, in the presence of two witnesses)

Address: ______________________________________________ Date of birth: __________________
(Insert your current address here)

### WITNESS SIGNATURES

*[**Note**: The following people cannot be witnesses: the attorney or his or her spouse or partner; the spouse, partner, or child of the person making the document, or someone that the person treats as his or her child; a person whose property is under guardianship or who has a guardian of the person; a person under the age of 18.]*

**Witness #1**: *Signature*: _____________________________ *Print Name*: __________________________

*Address:* _________________________________________________________________________

*Date signed*: ___________________

**Witness #2**: *Signature*: _____________________________ *Print Name*: __________________________

*Address:* _________________________________________________________________________

*Date signed*: ___________________