COMBINED FORM OF ADVANCE HEALTH CARE DIRECTIVE AND PROXY APPOINTMENT

SCHEDULE

(Sections 11(1)(a), 13(2) and 52)

Cayman Island Advance Health Care Directive: Planning for future health care decisions

The Health Care Decisions Law, 2019

By: _____ **Date of Birth:** _____

(Print Name) (Month/Day/Year)

This directive has two parts to state your wishes, and a third part for needed signatures.

Part 1 lets you answer this question: If you cannot (or do not want to) make your own health care decisions, who do you want to make them for you? The person you pick is called your proxy. More than one proxy can be appointed, in which case Part 1 will need to be expanded. Under the Law, proxies may act separately. **Make sure you talk to your proxy about this important role.**

Part 2 lets you write your preferences about efforts to extend your life in three (3) situations: terminal condition, persistent vegetative state, and end-stage condition.

Use the directive to reflect your wishes, then sign in front of two witnesses one of which shall be a doctor (Part 3). If your wishes change, make a new directive.

Make sure you give a copy of the completed directive to your proxy, your doctor, and others who might need it. Keep a copy at home in a place where someone can get it if needed. Review what you have written periodically.

Note: Marriage or divorce does not automatically revoke an advance health care directive. If you later marry or divorce you should review this directive and any proxy/ies appointed to see if this directive still agrees with your wishes.

Note: While a directive is operative, it prevails over any right of an attorney of the directive-maker or of the directive-maker's nearest relative.

Part 1: Appointment of Proxy

(Optional; directive valid if no proxy appointed)

A. Appointment

Note: To be eligible for appointment, an individual must be an adult, mentally competent and not your doctor or other registered practitioner.

I appoint the following individual/s as my proxy/ies to make health care decisions for me:

Name: _____

Address: _____

Date of Birth: _____

Home Phone: _____

Cell Phone: _____

(Optional for Additional Proxy. Directive Valid if left blank.)

Name: _____

Address: _____

Date of Birth: _____

Home Phone: _____

Cell Phone: _____

B. Powers and rights of proxy

Note:

1. *These powers and rights will only apply while you are not mentally competent.*
2. *These powers and rights are optional. Strike out and initial any that you do not wish to apply.*
3. *If nothing is provided for here, the default position is that your proxy will (subject to certain limitations) have full power to make decisions about your health care during any period in which you are not mentally competent.*

I want my proxy to have full power to make health care decisions for me, including the power to:

1. consent or not to consent to medical procedures and treatments which my doctors offer, including things that are intended to keep me alive, for example CPR/cardiopulmonary resuscitation, ventilators and feeding tubes;

2. decide who my doctor and other health care providers should be;

3. decide where I should be treated, including whether I should be in a hospital, nursing home, other medical care facility or hospice programme.

I also want my proxy to:

1. ride with me, if possible, in an ambulance if ever I need to be rushed to the hospital; and

2. be able to visit me, with the same access rights as my nearest relative, if I am in a hospital or any other health care facility.

This power is subject to the following conditions or limitations:

(Optional; Directive valid if left blank.)

C. How my proxy is to decide specific issues

I trust my proxy's judgment. My proxy should look first to see if there is anything in Part 2 of this directive that may help to decide the issue. Then, my proxy should think about the conversations we have had, my religious and other beliefs and values, my personality, and how I handled medical and other important issues in the past. If what I would decide is still unclear, then my proxy is to make decisions for me that my proxy believes are in my best interest. In doing so, my proxy should consider the benefits, burdens, and risks of the choices presented by my doctors.

D. People my proxy should consult

(Optional; Directive valid if left blank.)

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

Name	Telephone Number

E. In Case of Pregnancy

(Optional for women of child-bearing years only; Directive valid if left blank.)

F. Access to my health information

1. If, before my proxy has power to act, my doctor wants to discuss with that person my capacity to make myown health care decisions, I authorize my doctor to disclose protected health information relating to that issue.

2. Once my proxy has power to act, my proxy may request, receive, and review any information, oral or written, regarding my physical or mental health, including medical and hospital records and other protected health information, and consent to disclosure of this information.

3. For all purposes relating to my health care, my proxy is my personal agent during any period in which I am not mentally competent.

Part 2: Treatment Preferences

A. Statement of Goals and Values

(Optional; Directive valid if left blank.)
Note: Giving a directive does not affect you receiving palliative care.

I want to say something about my goals and values, and especially what is most important to me during the last part of my life.

B. Preference in Case of Terminal Condition

Note: 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. Directive valid if left blank.*

If my doctors certify that my death from a terminal condition is imminent, even if life-sustaining measures are used:

1. Keep me comfortable, which includes medication to relieve pain and distress, 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<< _____

2. Keep me comfortable, which includes medication to relieve pain and distress, 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<< _____

3. 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.

   _____

C. Preference in Case of Persistent Vegetative State

Note: 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. Directive valid if left blank.*

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:

1. Keep me comfortable, which includes medication to relieve pain and distress, 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<< _____

2. Keep me comfortable, which includes medication to relieve pain and distress, 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<< _____

3. 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 End-Stage Condition

Note: 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. Directive valid if left blank.*

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 mental capacity and complete physical dependency:

1. Keep me comfortable, which includes medication to relieve pain and distress 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<< _____

2. Keep me comfortable, which includes medication to relieve pain and distress, 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<<

3. 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. In Case of Pregnancy

(Optional, for women of child-bearing years only. Directive valid if left blank.)

If I am pregnant, my decision concerning life-sustaining procedures shall be modified as follows:

F. Effect of Stated Preferences

Note: Read both of these statements carefully. Then, ***initial one only.*** *Directive valid if left blank.*

1. I realize I cannot foresee everything that might happen after I can no longer decide for myself. My stated preferences are meant to guide whoever is making decisions on my behalf and my health care 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<<

2. 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 health care providers to follow my stated preferences exactly as written, even if they think that some alternative is better.

Part 3: Signature and Witnesses

By signing below, I indicate that I am mentally competent to make this directive and that I understand its purpose and effect. I also understand that this document replaces any similar advance health care directive I may have completed before this date. I declare that this directive is made voluntarily and without coercion, duress or inducement.

_____ _____

Signature of Directive-Maker *Date*

Witnessing doctor's statement:

The directive-maker signed this document in my presence. I am satisfied that:

(a) the directive-maker is an adult who is mentally competent;

(b) this directive was given voluntarily and without coercion, duress or inducement; and

(c) the directive-maker has been told about the nature and consequences of making this directive.

_____ _____

Signature of Witnessing Doctor *Date*

Doctor's name in print: _____

Doctor's registration number: _____

Signature of the other witness:

The directive-maker signed this document in my presence:*

_____ _____

Signature of Witness *Date*

*Witness' name in print:*_____

**Note: Certain people cannot be a witness. Anyone appointed under Part 1 of this directive as a proxy and anyone who is a beneficiary - that is a person who might benefit under the directive-maker's will or estate in intestacy or an insurance policy under which a life insured is, or includes, the directive-maker; or has an interest granted under an instrument under which the directive-maker is the donor, grantor or settlor - of the directive-maker are not eligible.*

CHECKLIST

Did you remember to:

- Fill out Part 1 if you want to name a proxy (or proxies)?
- Talk to your proxy about your values and priorities, and decide whether that's enough guidance or whether you also want to make specific health care decisions in your directive?
- If you want to make specific decisions, fill out Part 2, choosing carefully among alternatives?
- Sign and date the directive in Part 3, in front of a witnessing doctor and another independent witness?
- Did the witnessing doctor and the other witness also sign the directive just after you did?
- Make sure your proxy (if you named one), your family, and your doctor know about your advance health care planning

Give a copy of your directive to your:

- Proxy
- Family members
- Doctors
- Hospital
- Nursing Home (if applicable)