

Alaska

Search this site...



Home Services Locations News & Events Patients & Visitors Healthy Alaska Giving Why Choose Providence

Patients & Visitors

- Advance Directives
- Email A Patient
- Find A Doctor
- Mission Services
- MyChart
- Patient Safety Goals
- Pharmacy Services
- Privacy Practices
- Quality Measures
- Release of Information
- Reporting Concerns
- thestatus.com

Living Will/Power of Attorney

Patient Self-Determination Act

Providence Alaska Medical Center promotes a patient's right to participate actively in health care decision making. Through education and inquiry about Advance Directives, we encourage patients to communicate their preferences and values to others. Such communication will guide others in the health care decision making for the patient if the patient is unable to do so.

An Advance Directive is a formal document written in advance of an incapacitating illness that states a patient's choices regarding health care if the patient becomes unable to make decisions.

Download the Advance Directive Form

The suggested Alaska Advance Directive form contains two major important parts. First, the appointment of a health care agent, also called the Durable Power of Attorney for Health Care, and second, the instruction section called the Living Will or Health Care Directive (see below for a definition of these terms).

- Download in Adobe® PDF format
- Download in MS Word format
- Download the Advance Directive, simplified version

Providence Alaska Medical Center appreciates having a copy of a patient's Advance Directives but does not require patients to create Advance Directives and does not discriminate against those who choose not to write Advance Directives. Providence Alaska Medical Center provides each adult individual admitted as an inpatient with written information about:

- An individual's rights under Alaska state law to make decisions concerning medical care such as the right to accept or refuse medical or surgical treatment and the right to formulate an Advance Directive.
- Written policies of the hospital concerning the individual's rights to make health care and Advance Directive decisions, and the implementation of such decisions.

Providence Alaska Medical Center supports the goal of educating health care providers and the community about the value of Advance Directives and facilitates their appropriate use.

Definitions of Key Terms:

Durable Power of Attorney for Health Care

A legal document in which a person gives authority for making decisions about his/her health care to someone else. The document is usually written so that this authority is given only if the person becomes unable to make decisions for him/herself.

Health Care Directive (Living Will)

is the part of the document in which a person can stipulate the kind of life prolonging medical care he/she would or would not want if terminally ill or permanently unconscious and unable to make medical decisions or speak for him/herself.

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- Healthstream
- Publisher Login
- Road 2 Retirement

Alaska Advance Health Care Directive

This form lets you have a say about how you want to be treated if you get very sick.

❖ This form has 4 parts.

Part 1: Lets you choose a health care agent.

A health care agent is a person who can make medical decisions for you if you are too sick to make them yourself.

Part 2: Lets you make your own health care choices.

This form lets you choose the kind of health care you want.

This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

Part 3: Lets you make an anatomical gift (organ/tissue donation).

This section is optional.

Part 4: Is the place to sign this form to make it official.

It must be signed before it can be used.

You can fill out Part 1, Part 2, Part 3, or all three parts. Fill out **only** the parts you want. Always sign the form in Part 4.

If you only want a health care agent, go to Part 1 on page 3

If you only want to make your own health care choices known to those who care for you, go to Part 2 on page 6

If you want both then fill out both Part 1 and Part 2.

Always sign the form in Part 4 on page 10

➤ What do I do with the form after I fill it out?

Share the form with those who care for you:

- your agent
- family
- friends
- doctors
- nurses
- social workers



➤ What if I change my mind?

- Complete a new form.
- Tell your agent and those that care for you about any changes.
-

➤ What if I have questions about the form?

- Bring it to family, friends, doctors, nurses, clergy, or social workers to answer your questions.

➤ What if I want to make health care choices that are not on this form?

- Write your choices on a piece of paper.
- Keep the paper with this form.
- Share your choices with your agent and with those who care for you.

PART 1: Choose your health care agent

Your health care agent makes medical decisions for you if you are too sick to make them yourself.

- **Whom should I choose to be my health care agent?**
 - A family member or friend who:
 - is at least 18 years old
 - knows you well and understands your wishes
 - can be there for you when you need them
 - you trust to do what is best for you
 - can tell your doctors about the decisions you made on this form

Your agent cannot be your doctor or someone who works at the hospital or clinic, *unless* he or she is a family member.

- **What will happen if I do not choose a health care agent?**
 - If you are too sick to make your own decisions, your doctors will ask your closest family members to make decisions for you.
 - If you want your agent to be someone other than family, you must write his or her name on this form.

- **What kind of decisions can my health care agent make?**
 - Agree to, say no to, change, stop, or choose:
 - doctors, nurses, social workers
 - hospitals, clinics, or nursing homes
 - medications, tests, and surgeries

PART 1: Choose your health care agent (continued)

(1.) Your Health Care Agent

- **I want this person to help make my medical decisions for me:**

first name

last name

address

city

state

zip code

() _____

home phone number

() _____

work phone number

- **OPTIONAL: If the person listed above cannot do it, then I want this person to help make my medical decisions for me:**

first name

last name

street address

city

state

zip code

() _____

home phone number

() _____

work phone number

- **OPTIONAL: If neither person listed above can do it, then I want this person to help make my medical decisions for me:**

first name

last name

street address

city

state

zip code

() _____

home phone number

() _____

work phone number

(2.) What my health care agent can do:

My health care agent can make all medical decisions including whether or not I get artificially given food and water, or any other kind of health care to keep me alive except those that I don't want, which I have listed here: _____

(Add additional sheets of paper if you need to.)

(3.) When can my health care agent make decisions for me?

- Put an X next to the sentence you agree with:

[] My health care agent can make decisions for me **now**.

[] My health care agent will make decisions for me **only** after I cannot make my own decisions.

PART 2: Make your own health care choices

Write down your choices so those who care for you will not have to guess.

(4.) Think about what makes your life worth living.
(If your health care agent knows what is important to you, he or she will know how to make your decisions).

Put an X next to all the sentences you agree with.

What really makes my life important is:

- being able to care for myself
- talking with family and friends
- being free from pain
- living without being hooked up to machines
- I am not sure
- Other (please specify) _____

My life is always worth living no matter how sick I am or how much I need machinery to stay alive.

Other (please specify) _____

I would prefer to die:

- At home
 - In the hospital
 - I am not sure
 - Other (please specify) _____
-

Your doctors and nurses will always try to keep you comfortable and free from pain.

PART 2: Make your own health care choices (continued)

Write down your choices so those who care for you will not have to guess.

(5.) End-of-Life Decisions

I want my doctors and others involved in my care to provide or not to provide medical treatment based on the choices I have marked below and the values I listed in #4:

Please read this whole page before you make your choices.

Put an X next to the sentence you most agree with (either (A.) or (B.))

(A.) Choice To Live as Long as Possible –

I want all life prolonging treatments indefinitely, no matter how sick I am; **OR**

(B.) Choice Not To Prolong Dying – (Choose all the ones you agree with.)

I want to be kept comfortable and I do not want my life to be prolonged with medical treatment **IF:** (please write your initials next to **all** the choices that match your wishes.)

_____ I have a medical problem that my doctors believe will result in my death within a short time, even with the medical care they could give me.

_____ The use of life support treatments would only prolong my dying process without hope of getting better.

_____ I am in a coma and it is likely that I will never be awake and aware again.

_____ The treatments needed to keep me from dying are painful, or otherwise place a big burden on my family or me, and have little chance of improving my health.

Please write down and initial any other instructions that match your end-of-life wishes _____

PART 2: Make your own health care choices (continued)

Write down your choices so those who care for you will not have to guess.

(6.) Artificially given Food and Liquids (Artificially given food and liquids are provided by a tube placed through your nose down your throat to the stomach, or by a tube placed directly through your stomach wall into the stomach, or into a tube in your veins.)

Please mark your choice with an “X” or write down instructions.

If I am not able to safely take in food and/or liquids:

____ I want to receive artificially given food and liquids indefinitely;

OR

____ I want to receive artificially given food and liquids for a limited time to see if I can improve;

OR

____ As indicated in section (B.) on page 7, I do not wish to receive artificially given food and liquid to keep me from dying.

OR

____ Other Instructions about food and liquids _____

(7.) Relief from Pain

I want my pain treated adequately, even if it makes me sleepy or means I might die sooner **unless** I give other wishes about treatment of pain here:

(8.) Other Wishes

If you have other instructions or information to share with your health care agent, or doctor, please do so here (Examples: drug allergies, wishes about blood transfusions):

PART 3: Anatomical Gift at Death (organ/tissue donation)

This section of the form is optional – **you only have to complete it if you want to donate.**

Donating (giving) your organs/tissues can help save lives.

If you leave this part of the form (Part 3) blank your health care agent may still be asked to give permission to donate (give) your organs upon your death.

(9.) Upon my death: (mark the box you most agree with)

(A.) I *do not wish* to donate any organs or tissues.

(B.) I wish to give *any* needed organs, tissues, or other body parts,

OR

(C.) I wish to give *only* the organs, tissues, or other body parts listed here:

(D.) My gift may be used for: (check any or all that apply)

transplant;

therapy;

research;

education

PART 4: Sign the form (continued)

If you do not have witnesses, take this form to a notary public (at banks, hospitals, or check your local yellow pages) and have it signed on page 12.

Have your witnesses sign their names and write the date

- Witness #1

_____/_____
sign your name / date

print your first name print your last name

street address

city state zip code

() _____ () _____
home phone number work phone number

- Witness #2 (*not* a family member)

_____/_____
sign your name / date

print your first name print your last name

street address

city state zip code

() _____ () _____
home phone number work phone number

YOU ARE NOW DONE WITH THIS FORM.

Share this form with your health care agent, friends, family, doctors, nurses, and social workers, and your hospital.

NOTARY PUBLIC

- Take this form to a notary public ONLY if two witnesses have not signed this form.
 - Bring photo I.D. (driver's license, passport, etc.)
-

CERTIFICATE OF ACKNOWLEDGEMENT OF NOTARY
PUBLIC
STATE OF ALASKA

State of Alaska _____ Judicial District
On this _____ day of _____, in the year _____,
before me, _____
(print name of notary public)

appeared _____
(print name of person completing form)
personally known to me (or has proven to me on the basis of
satisfactory evidence) to be the person whose name is subscribed to
this instrument, and acknowledgement that the person executed it.

NOTARY SEAL

Signature of Notary Public

Date

YOU ARE NOW DONE WITH THIS FORM.

Share this form with your health care agent, friends, family, doctors, nurses, and social workers,
and your hospital.