TENNESSEE
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
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CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- Learn about options for end-of-life services and care
- Implement plans to ensure wishes are honored
- Voice decisions to family, friends and health care providers
- Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives. If you have other questions regarding these documents, we recommend contacting your state attorney general's office.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:

    - Instructions for preparing your advance directive, please read all the instructions.
    - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR TENNESSEE ADVANCE DIRECTIVE

This packet contains a legal document, known as a Tennessee Advance Directive, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. This document is based on forms created by the Tennessee Department of Health.

Page one includes an Appointment of Health Care Agent. This lets you name someone, called an agent, to make decisions about your medical care — including decisions about life support — if you can no longer speak for yourself. An agent can speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Pages two and three contain an Individual Instruction that lets you provide your wishes regarding medical care in the event that you can no longer speak for yourself. In addition to health care decisions, the individual instruction portion of the form also allows you to give instructions regarding your other advance planning concerns, such as your burial wishes. Finally, the individual instruction portion of the form allows you to make a declaration of your wishes regarding organ donation.

Your advance directive goes into effect when your designated physician determines that you are no longer able to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision.

This form does not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a Declaration for Mental Health Treatment. The Tennessee Department of Mental Health and Developmental Disabilities has published a form declaration for mental health treatment at www.state.tn.us/mental/t33/DHMT_FORM.pdf and a guide to the form at www.state.tn.us/mental/t33/DMHT_bro.pdf.

Note: These documents will be legally binding only if the person completing them is a competent adult, 18 years or older, or an emancipated minor.

COMPLETING YOUR TENNESSEE ADVANCE DIRECTIVE

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

You can appoint a second person as your alternate agent. The alternate will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

How do I make my Tennessee Advance Directive legal?

You must sign your advance directive. Your signature must either be notarized or witnessed by two competent adults. Either option is available with this form.

If you have your signature witnessed, the witnesses cannot be the person you name as your agent. In addition, at least one of your witnesses must be a person 1) who is not related to you by blood, marriage, or adoption; and 2) who will not inherit any part of your estate.

Should I add personal instructions to my Tennessee Advance Directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke all or part of your advance directive, except for the designation of an agent, at any time you have capacity and in any manner that communicates an intent to revoke. This could include tearing, burning, or otherwise destroying the document or simply stating orally that you intend to revoke your advance directive.

You may revoke the designation of your agent only by a signed writing or by personally informing your supervising health care provider. If your spouse is your agent, a decree of annulment, divorce, dissolution of marriage, or legal separation automatically revokes his or her power, unless you specify otherwise in your advance directive.

You can also draft a new advance directive. An advance directive that conflicts with an earlier advance directive revokes the earlier directive to the extent of the conflict.

INSERT YOUR NAME

ADD YOUR AGENT'S NAME, PHONE NUMBER, RELATION TO YOU, AND ADDRESS

ADD YOUR ALTERNATE AGENT'S NAME, PHONE NUMBER, RELATION TO YOU, AND ADDRESS

ADD ANY LIMITATIONS OR INSTRUCTIONS YOU HAVE FOR YOUR AGENT

APPOINTMENT OF HEALTH CARE AGENT

I, _____, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:

Name: _____ Phone #: _____

Relation: _____

Address:

_____

_____

Alternate Agent:

Name: _____ Phone #: _____

Relation: _____

Address:

_____

_____

Other Instructions or Limitations for my Agent:

_____

_____

_____

_____

_____

_____

_____

_____

INSERT YOUR NAME

QUALITY OF LIFE STATEMENT

CHECK THE BOXES FOR CONDITIONS THAT YOU DO NOT CONSIDER AN ACCEPTABLE QUALITY OF LIFE

YOU CAN CHECK AS MANY OF THESE ITEMS AS YOU WANT, OR ADD ADDITIONAL CONDITIONS IN THE "OTHER INSTRUCTIONS" SECTION BELOW

TREATMENT INSTRUCTIONS

CHECK THE "YES" BOXES IF YOU WANT TO RECEIVE THE TREATMENT

CHECK THE "NO" BOXES IF YOU DO NOT WANT TO RECEIVE THE TREATMENT

INDIVIDUAL INSTRUCTION

I, _____, hereby give these individual 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.

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. I do not consider the following conditions to be an acceptable quality of life:

☐ Permanent Unconscious Condition: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

☐ 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.

☐ Dependent in all Activities of Daily Living: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.

☐ End-Stage Illnesses: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to a feeling of suffocation.

If my condition is irreversible – that is, it will not improve – I direct that medically appropriate treatment be provided as indicated below. If I mark "No" below, I authorize the withholding or withdrawal of such care:

☐ 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 primary illness.

☐ Yes ☐ No Artificially Provided Nourishment and Fluids: Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

OTHER INSTRUCTIONS

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

Other Instructions (Optional):

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Organ Donation (Optional)

CHECK THE APPROPRIATE BOXES

☐ Upon my death, I DO NOT wish to make an anatomical gift

☐ Upon my death, I wish to make the following anatomical gift (please mark one):

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

IF YOU WANT TO LIMIT YOUR ANATOMICAL GIFT, INDICATE THE LIMITATION HERE.

_____

_____

_____

_____

_____

SIGNATURE

Your signature must either be witnessed by two competent adults (Option A, below) or notarized (Option B, below). If witnessed, neither witness may be the person you appointed as your agent, and at least one of the witnesses must be someone who is not related to you by blood, marriage, or adoption or entitled to any part of your estate.

OPTION A: SIGN WITH WITNESSES

PRINT YOUR NAME

_____
Principal's name (please print or type)

SIGN AND DATE YOUR ADVANCE DIRECTIVE

_____
Signature of Principal Date
(must be at least 18 or emancipated minor)

I am a competent adult and have not been named as the Principal's agent. I witnessed the Principal's signature on this form.

SIGNATURE OF WITNESS 1

_____
Signature of witness number 1 Date

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

SIGNATURE OF WITNESS 2

_____
Signature of witness number 2 Date

OPTION B: SIGN BEFORE A NOTARY

PRINT YOUR NAME

_____
Principal's name (please print or type)

SIGN AND DATE YOUR ADVANCE DIRECTIVE

_____
Signature of Principal Date

STATE OF TENNESSEE

COUNTY OF _____

HAVE YOUR SIGNATURE NOTARIZED

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 "Principal." The Principal 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 Principal appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____

_____
Signature of Notary Public

You Have Filled Out Your Health Care Directive, Now What?

1. Your Tennessee Advance Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Tennessee document.

7. Be aware that your Tennessee document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician if you are interested in obtaining this form. CaringInfo does not distribute these forms.

Congratulations!

You've downloaded your free, state specific advance directive.

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and CaringInfo allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

I hope you will show your support for our mission and make a tax-deductible gift today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a generous tax-deductible gift of $23, $47, $64, or the most generous amount you can send.

You can help us provide resources like this advance directive FREE by sending in your gift to help others.

Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

YES! I want to support the important work of the National Hospice Foundation.

$23	helps us provide free advance directives
$47	helps us maintain our free InfoLine
$64	helps us provide webinars to hospice

Return to:
National Hospice Foundation
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OR donate online today: www.caringinfo.org/donate