IT'S YOUR LIFE. IT'S YOUR CHOICE.

DYING WITH DIGNITY CANADA

BRITISH COLUMBIA

Advance Directive/ Representation Agreement (Section 9)

A. NOTES

A1 **To complete an Advance Directive and Representation Agreement, you (the "Adult") must:**

- Be **19** years of age or older
- Be mentally capable

A2 **"Representative" = Appointed Substitute Decision-Maker**

A3 **A Representative must:**

- Be **19** years of age or older
- **NOT** provide paid personal care or health care to you
- **NOT** be the employee of a facility where you live and through which you receive personal care or health care (unless they are your child, parent, or spouse)
- Agree to be your Representative

A4 **You must sign your Advance Directive and Representation Agreement in the presence of TWO witnesses.**

A5 **If you cannot physically complete and sign this Advance Directive and Representation Agreement yourself, someone else can sign it for you. This must be done in your presence and the presence of a witness. This person cannot be your Representative or one of your witnesses. Anyone who is not qualified to be a witness cannot sign on your behalf.**

A6 **The witnesses must:**

- Be **19** years of age or older
- **NOT** be the same person you chose as your Representative, nor their spouse, child, parent, employee, or agent
- **NOT** provide paid personal care, health care, or financial services to you, or be that paid person's spouse, child, parent, employee or agent
- Understand your type of communication, unless the witness receives interpretive assistance
- Sign the Advance Directive and Representation Agreement in your presence and the presence of the other witness. Only one witness is required if they are a lawyer or a member in good standing of the Society of Notaries Public of British Columbia

A7 **Personal care decisions (Section C) refer to the daily living needs of individuals, such as living arrangements, diet, clothing, hygiene, exercise, and safety.**

A8 **If you feel you have special circumstances that the Dying With Dignity Canada forms do not address, we suggest that you consult with a lawyer.**

B. PERSONAL INFORMATION

B1 **I,** _____ **revoke (cancel) any previous Advance Directives and Representation Agreements made by me. I understand that for revocation to be effective, I need to give written notice to my Representative(s).**
(NAME)

B2 **Legal first name:** _____

B3 **Legal last name:** _____

B4 **Preferred name** (If different from legal name)**:** _____

B5 **Pronouns** (Optional)**:** _____

B6 **Date of birth:** _____

B7 **Address:** _____

B8 **Phone:** _____

B9 **Email:** _____

C. APPOINTING A REPRESENTATIVE
(RECOMMENDED, BUT OPTIONAL)

C1 I appoint (choose) the following people to make health care and personal care decisions for me if I am no longer capable of making health care decisions for myself:

REPRESENTATIVE #1

C2 **First name:** _____

C3 **Last name:** _____

C4 **Relationship to me:** _____

C5 **Address:** _____

C6 **Phone:** _____

C7 **Email:** _____

REPRESENTATIVE #2 (OPTIONAL, IF REPRESENTATIVE #1 DIES, RESIGNS, IS MY SPOUSE AT THE TIME OF THIS REPRESENTATION AGREEMENT AND OUR RELATIONSHIP ENDS, OR BECOMES INCAPABLE)

C8 A statutory declaration can be completed by you, your Representative, or your alternate Representative. This declaration would provide evidence that your alternate Representative can act in place of your Representative, because one of the circumstances above occurred. You can download a "Statutory declaration for evidence of authority of alternate representative" from the Government of British Columbia.

C9 **First name:** _____

C10 **Last name:** _____

C11 **Relationship to me:** _____

C12 **Address:** _____

C13 **Phone:** _____

C14 **Email:** _____

C15 _____ (INITIAL) I authorize my Representative to do anything they consider necessary in relation to my health care and personal care, under section 9 (1) (a) of the ***Representation Agreement Act***.

D. HEALTH CARE DIRECTIONS
(PLEASE READ EACH LINE CAREFULLY)

D1 _____ (INITIAL) **I understand that a health care provider may not provide me with any health care for which I refuse consent in this Advance Directive and Representation Agreement.**

D2 _____ (INITIAL) **I understand that a person may not be chosen to make decisions on my behalf for any health care for which I have given or refused consent in this Advance Directive and Representation Agreement.**

D3 _____ (INITIAL) **A health care provider may act on an instruction set out in this Advance Directive and Representation Agreement without consent of my Representative.**

D4 _____ (INITIAL) **The instructions provided in this Advance Directive and Representation Agreement will still stand even if there are significant changes in medical knowledge, practice, or technology.**

D5 _____ (INITIAL) **If I am sedated and unable to communicate, I would like the sedation lifted so that I can decide for myself to accept or refuse a particular therapy.**

D6 **Initial only ONE of the following two options. If you choose Option 1, skip to D7.**

_____ (INITIAL) **Option 1:** I direct that my life be prolonged, and that I be provided **all life-sustaining treatments** that apply to my medical condition.

OR

_____ (INITIAL) **Option 2:** I direct that I **only receive care that will keep me comfortable and pain free**, and that my life is not prolonged (initial the options that apply below).

_____ (INITIAL) **In any circumstance**

_____ (INITIAL) **If I experience a serious life-threatening illness that cannot be reversed**

_____ (INITIAL) **If I experience permanent, chronic, and debilitating suffering**

_____ **If I have advanced dementia** (please describe what this would look like for you)
(INITIAL)

_____ **OTHER** (please explain)
(INITIAL)

D7 **I specifically REFUSE (say no to) the following (initial where you refuse):**

_____ **Electrical, mechanical, or other artificial stimulation of my heart** (such as CPR)
(INITIAL)

_____ **Respirator or ventilator**
(INITIAL)

_____ **Artificial feeding such as through a stomach tube, or an intravenous line** (IV)
(INITIAL)

_____ **Being spoon fed, if I am no longer able to feed myself**
(INITIAL)

_____ **Artificial hydration** (fluids) **by intravenous line**
(INITIAL)

_____ **Antibiotics**
(INITIAL)

_____ **Transfer to an intensive care unit or similar facility**
(INITIAL)

D8 **I would prefer to be cared for (select one):**

_____ **At home**
(INITIAL)

_____ **In hospice**
(INITIAL)

_____ **In hospital**
(INITIAL)

D9 _____ (INITIAL) **If my health care provider will not follow this Advance Directive and Representation Agreement, I ask that my care be transferred to another health care provider who will respect my legal rights.**

D10 _____ (INITIAL) **If I should be a patient in a health care facility which will not follow this Advance Directive and Representation Agreement, I ask that I be transferred to another facility.**

ADDITIONAL DIRECTIONS:

MEDICAL ASSISTANCE IN DYING AND ADVANCE REQUESTS

D11 I understand that the current laws of Canada do not allow me to request medical assistance in dying (MAID) in advance. I understand that my Representative cannot consent to MAID on my behalf. If the law changes, here are my directions regarding MAID. I wish for my Representative and health care providers to act on my directions below.

E. SIGNATURES

MY SIGNATURE (THE "ADULT")

E1 **First name:** _____

E2 **Last name:** _____

E3 **Signature:** _____

E4 **Date:** _____

OR

SIGNATURE ON MY BEHALF IF I AM PHYSICALLY UNABLE TO SIGN THE ADVANCE DIRECTIVE AND REPRESENTATION AGREEMENT (IN THE PRESENCE OF THE WITNESSES BELOW)

E5 **First name:** _____

E6 **Last name:** _____

E7 **Relationship to the "Adult":** _____

E8 **Signature:** _____

E9 **Address:** _____

E10 **Phone:** _____

E11 **Email:** _____

E12 **Date:** _____

REPRESENTATIVE #1

I agree to be the Representative for the person who created this Advance Directive and Representation Agreement. I understand the responsibilities that come with this role under the ***Health Care (Consent) and Care Facility (Admission) Act***, and the ***Representation Agreement Act***.

E13 **First name:** _____

E14 **Last name:** _____

E15 **Signature:** _____

E16 **Date:** _____

REPRESENTATIVE #2 (OPTIONAL)

I agree to be the Representative for the person who created this Advance Directive and Representation Agreement if Representative #1 dies, resigns, is the Adult's spouse at the time of this Representation Agreement and their relationship ends, or becomes incapable. I understand the responsibilities that come with this role.

E17 **First name:** _____

E18 **Last name:** _____

E19 **Signature:** _____

E20 **Date:** _____

WITNESS #1

I certify that I witnessed the signing of this Advance Directive and Representation Agreement.

E21 _____ **I am a lawyer.**
(INITIAL)

E22 _____ **I am a member in good standing of the Society of Notaries Public of British Columbia.**
(INITIAL)

E23 **First name:** _____

E24 **Last name:** _____

E25 **Signature:** _____

E26 **Address:** _____

E27 **Phone:** _____

E28 **Email:** _____

E29 **Date:** _____

WITNESS #2 (NOT REQUIRED IF WITNESS #1 IS A LAWYER OR MEMBER IN GOOD STANDING OF THE SOCIETY OF NOTARIES PUBLIC OF BRITISH COLUMBIA)

I certify that I witnessed the signing of this Advance Directive and Representation Agreement.

E30 **First name:** _____

E31 **Last name:** _____

E32 **Signature:** _____

E33 **Address:** _____

E34 **Phone:** _____

E35 **Email:** _____

E36 **Date:** _____

F. DISTRIBUTION

I have shared this Advance Directive and Representation Agreement with the following people. This is a reminder to me to keep these people informed of any changes. I am aware that outdated copies of my Advance Directive and Representation Agreement may create confusion.

F1 **Name:** _____

F2 **Name:** _____

F3 **Name:** _____

F4 **Name:** _____

F5 **Name:** _____

F6 **Name:** _____

G. REVIEW

G1 You should review your Advance Directive and Representation Agreement:

- At least every three years
- When your health situation changes
- When your Representative(s) change(s)

_____ **Date of last review:** _____
(INITIAL)

_____ **Date of last review:** _____
(INITIAL)

_____ **Date of last review:** _____
(INITIAL)

_____ **Date of last review:** _____
(INITIAL)

H. NEXT STEPS

H1 **After completing your Advance Directive and Representation Agreement, re-read it to ensure your preferences are clear.** Then, review it with your Representative(s). If a health care provider does not know you, they may need the Advance Directive and Representation Agreement to understand your wishes for care.

H2 Keep a copy of your Advance Directive and Representation Agreement in an easy-to-find place in an emergency. Leave a note in a prominent place, such as on your fridge with a magnet. This will let emergency personnel know where to look and who to call in a crisis. You can also print a wallet card and fridge note from the Dying With Dignity Canada website at ***dyingwithdignity.ca/advance-care-planning***.

H3 **Do not store your Advance Directive and Representation Agreement in any locked box, drawer or safe.**

H4 Discuss your completed Advance Directive and Representation Agreement with your health care provider. Give them a copy to put in your medical file. However, do not assume that doing so will result in your Advance Directive and Representation Agreement being available in an emergency. You or your Representative(s) must ensure health care providers are provided with a copy of your Advance Directive and Representation Agreement. That is why you should appoint a Representative.

H5 If there are no changes to be made, sign the Advance Directive and Representation Agreement again with the new date.

H6 Your medical condition may change. Or you may reconsider some of the directions you wrote down. Download a new Advance Directive and Representation Agreement at ***dyingwithdignity.ca/advance-care-planning*** or call Dying With Dignity Canada (DWDC) toll free at **1-800-495-6156** to receive a copy in the mail. Tell everyone involved in your care that you have updated your Advance Directive and Representation Agreement.