

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



PRINCE EDWARD ISLAND

Health Care Directive

A.NOTES

A1 “Health Care Directive” = Advance Directive

A2 To complete a Health Care Directive or assign a Proxy, you (the “Maker”) must:

- Be **16** years of age or older
- Be capable (Have capacity to make decisions with respect to treatment)

A3 “Proxy” = Substitute Decision-Maker

A4 A Proxy must:

- Be **16** years of age or older
- Agree to be your Proxy in writing. If the Proxy does not sign this Health Care Directive, their appointment is invalid.

A5 The Maker’s spouse or partner can be appointed as Proxy, but the appointment will be revoked if the person ceases to be the spouse or partner of the Maker.

A6 If you cannot complete and sign this Health Care Directive 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 Proxy, Proxy’s spouse, or a witness.

A7 A witness is only required if someone else is signing on your behalf.

A8 The witness must:

- **NOT** be the same person you chose as your Proxy, nor their spouse
- Sign the Health Care Directive in your presence

A9 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, _____ ^(NAME) revoke (cancel) any previous Health Care Directives made by me.

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: _____

B10 Personal Health Number: _____



C. APPOINTING A PROXY

(RECOMMENDED, BUT OPTIONAL)

C1 I appoint (choose) the following people to make health care decisions for me if I am not capable of making or communicating decisions for myself:

PROXY #1

C2 First name: _____

C3 Last name: _____

C4 Relationship to me: _____

C5 Address: _____

C6 Phone: _____

C7 Email: _____

PROXY #2 (OPTIONAL)

C8 First name: _____

C9 Last name: _____

C10 Relationship to me: _____

C11 Address: _____

C12 Phone: _____

C13 Email: _____

NOTE: Only complete the next section if you choose more than one Proxy.

C14 I want my Proxies to act:

_____ **Jointly** (They need to make decisions together)
(INITIAL)

_____ **Consecutively** (The second Proxy will only make decisions if the first
(INITIAL) is unavailable)



D. HEALTH CARE DIRECTIONS

(PLEASE READ EACH LINE CAREFULLY)

D1 _____ If I am sedated and unable to communicate, I would like the sedation
(INITIAL) lifted so that I can decide for myself to accept or refuse a particular therapy.

D2 Initial only **ONE** of the following two options. If you choose Option 1, skip to page 6.

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

OR

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

_____ **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**
(INITIAL)

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

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

D3 I specifically **REFUSE** (say no to) the following (initial where you refuse):

(INITIAL) **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**

D4 I would prefer to be cared for (select one):

(INITIAL) **At home**

(INITIAL) **In hospice**

(INITIAL) **In hospital**

D5 _____
(INITIAL) **If my health care provider will not follow this Health Care Directive, I ask that my care be transferred to another health care provider who will respect my legal rights.**

D6 _____
(INITIAL) **If I should be a patient in a health care facility which will not follow this Health Care Directive, I ask that I be transferred to another facility.**

ADDITIONAL DIRECTIONS:



E. SIGNATURES

MY SIGNATURE (THE “MAKER”)

E1 First name: _____

E2 Last name: _____

E3 Signature: _____

E4 Date: _____

OR

SIGNATURE ON MY BEHALF (IN THE PRESENCE OF THE WITNESS BELOW)

E5 First name: _____

E6 Last name: _____

E7 Relationship to the “Maker”: _____

E8 Signature: _____

E9 Address: _____

E10 Phone: _____

E11 Email: _____

E12 Date: _____



PROXY #1

I agree to be the Proxy for the person who created this Health Care Directive. I understand the responsibilities that come with this role.

E13 First name: _____

E14 Last name: _____

E15 Signature: _____

E16 Date: _____

PROXY #2 (OPTIONAL)

I agree to be the Proxy for the person who created this Health Care Directive. I understand the responsibilities that come with this role.

E17 First name: _____

E18 Last name: _____

E19 Signature: _____

E20 Date: _____

WITNESS (IF THE HEALTH CARE DIRECTIVE IS SIGNED BY SOMEONE ELSE ON THE MAKER'S BEHALF)

I certify that I witnessed the signing of this Health Care Directive. I declare that I am not the Proxy nor the spouse of the Proxy.

E21 First name: _____

E22 Last name: _____

E23 Signature: _____

E24 Address: _____

E25 Phone: _____

E26 Email: _____

E27 Date: _____



F. DISTRIBUTION

I have shared this Health Care Directive 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 Health Care Directive may create confusion.

F1 Name: _____

F2 Name: _____

F3 Name: _____

F4 Name: _____

F5 Name: _____

F6 Name: _____

G. REVIEW

G1 You should review your Health Care Directive:

- At least every three years
- When your health situation changes
- When your Proxy/Proxies change(s)

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

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

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

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



H. NEXT STEPS

- H1 After completing your Health Care Directive, re-read it to ensure your preferences are clear.** Then, review it with your Proxy/Proxies. If a health care provider does not know you, they may need the Health Care Directive to understand your wishes for care.
- H2** Keep a copy of your Health Care Directive 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 Health Care Directive in any locked box, drawer or safe.**
- H4** Discuss your completed Health Care Directive 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 Health Care Directive being available in an emergency. You or your Proxy/Proxies must ensure health care providers are provided with a copy of your Health Care Directive. That is why you should appoint a Proxy.
- H5** If there are no changes to be made, sign the Health Care Directive 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 Health Care Directive 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 Health Care Directive.

