SASKATCHEWAN

Health Care Directive

A. NOTES

A1 **“Health Care Directive” = Advance Directive**

A2 **To complete a Health Care Directive and appoint a Proxy, you (the “Maker”) must:**

- Be **16** years of age or older

A3 **“Proxy” = Substitute Decision-Maker**

A4 **A Proxy must:**

- Be **18** years of age or older
- Agree to be your Proxy

A5 **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 or the Proxy’s spouse.**

A6 **This Health Care Directive does not need to be witnessed if you sign it yourself. However, this Health Care Directive must be witnessed if someone else is signing on your behalf.**

A7 **The witness must:**

- Be **18** years of age or older
- **NOT** be the same person you chose as your Proxy, nor their spouse
- Sign the Health Care Directive in your presence

A8 **Amendments to *The Health Care Directives and Substitute Health Care Decision Makers Act, 2015* allow for virtual signature of a directive by video conference. There are important regulations in place for virtual signatures in Saskatchewan, and failure to follow the regulations may invalidate your Health Care Directive. Learn more about the regulations at *canlii.ca/t/55fq1*.**

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, ______________________________ revoke (cancel) any previous Health Care Directives made by me.**
(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 PROXY
(RECOMMENDED, BUT OPTIONAL)

C1 I appoint (choose) the following people to make health care decisions for me if I no longer have the capacity to make health care 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 is unavailable)
(INITIAL)

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

D1 ____________ (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.**

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

____________ (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**

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

____

____

____

____

____________ (INITIAL) **OTHER** (please explain)

____

____

____

____

____

D3 **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)

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

______ **At home**
(INITIAL)

______ **In hospice**
(INITIAL)

______ **In hospital**
(INITIAL)

D5 ______ **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.**
(INITIAL)

D6 ______ **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.**
(INITIAL)

ADDITIONAL DIRECTIONS:

____

____

____

____

____

____

MEDICAL ASSISTANCE IN DYING AND ADVANCE REQUESTS

D7 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 Proxy cannot consent to MAID on my behalf. If the law changes, here are my directions regarding MAID. I wish for my Proxy and health care providers to act on my directions below.

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 (OPTIONAL – SEE NOTES ON PAGE 2)

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)

__________ **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 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.