

## Advance Directives

### Helping You Control Your Health Care.

Many people have specific ideas about the kind of treatment they would like to receive in the case of a serious illness or injury. Often the people in this situation are unable to speak for themselves and make their wishes known.

Friends, family members and doctors are left to make the decisions. Sometimes they are not sure what is best or disagree on what the patient would want. Advance directives remove this burden and make sure that everyone knows how you want to be treated.

BlueCross BlueShield of Tennessee is providing information on your options and the forms required to help you and your family. Your doctor or your lawyer can give you advice on how to make these documents a part of your medical records. They need to be accessible when you need them.

You are not required by law to have any advance directives in place. It is entirely your decision.

#### **Advanced Care Plan Forms**

Machines and medicine can keep people alive when they otherwise might die. Under the Tennessee Right to Natural Death Act, you can decide if you want to be kept alive by machines and for how long. You can do this with a “Advanced Care Plan.”

An Advanced Care Plan should be completed while you can still think for yourself. Advanced Care Plans tells your friends and family how you would want your terminal illness to be treated. The document must be signed in front of two witnesses.

One copy of your Advanced Care Plan should be left with your doctor as part of your medical records. Another copy should be left with the person who you think would make a medical decision for you, if needed. The original copy should be with your other important papers.

Once your Advanced Care Plan is signed and witnessed, it is your rule. It stays so unless you change your mind. As long as you can still think for yourself, you can decide about your health care without an Advanced Care Plan.

If you have any questions about your coverage, please call us toll free at 1-800-841-7434 (TTY/TDD: 1-888-423-9490), 8 a.m. to 9 p.m. Eastern Time, 7 days a week. From March 2 to October 14, you may be required to leave a message on holidays and weekends. Your call will be returned the next business day.



## ADVANCE CARE PLAN

*Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.*

I, \_\_\_\_\_, hereby give these advance 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.

**Agent:** I want the following person to make health care decisions for me:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Address: \_\_\_\_\_

**Alternate Agent:** If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Address: \_\_\_\_\_

**Quality of Life:**

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (**you can check as many of these items as you want**):

- 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 needed most of the time and activities are limited due to the feeling of suffocation.

**Treatment:**

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. **Checking “yes” means I WANT the treatment. Checking “no” means I DO NOT want the treatment.**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b><u>CPR (Cardiopulmonary Resuscitation):</u></b> To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b><u>Life Support / Other Artificial Support:</u></b> Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b><u>Treatment of New Conditions:</u></b> Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b><u>Tube feeding/IV fluids:</u></b> 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, such as burial arrangements, hospice care, etc.:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Attach additional pages if necessary)

Organ donation (optional): 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: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**SIGNATURE**

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: \_\_\_\_\_  
(Patient)

DATE: \_\_\_\_\_

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

\_\_\_\_\_  
Signature of witness number 1

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

\_\_\_\_\_  
Signature of witness number 2

This document may be notarized instead of witnessed:

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STATE OF TENNESSEE  
COUNTY OF \_\_\_\_\_

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 who signed as the "patient". The patient 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 patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public

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**WHAT TO DO WITH THIS ADVANCE DIRECTIVE**

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent

**APPOINTMENT OF HEALTH CARE AGENT**

(Tennessee)

I, \_\_\_\_\_, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself, including any health care decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:

Alternate:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
City State Zip Code

(\_\_\_\_\_) \_\_\_\_\_  
Area Code Home Phone Number

(\_\_\_\_\_) \_\_\_\_\_  
Area Code Home Phone Number

(\_\_\_\_\_) \_\_\_\_\_  
Area Code Work Phone Number

(\_\_\_\_\_) \_\_\_\_\_  
Area Code Work Phone Number

(\_\_\_\_\_) \_\_\_\_\_  
Area Code Mobile Phone Number

(\_\_\_\_\_) \_\_\_\_\_  
Area Code Mobile Phone Number

\_\_\_\_\_  
Patient's name (please print or type) Date

\_\_\_\_\_  
Signature of patient (must be at least 18 or emancipated minor)

To be legally valid, **either** block A **or** block B must be properly completed and signed.

Block A Witnesses (2 witnesses required)

1. I am a competent adult who is not named above.  
I witnessed the patient's signature on this form.

\_\_\_\_\_  
Signature of witness number 1

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

\_\_\_\_\_  
Signature of witness number 2

Block B Notarization

STATE OF TENNESSEE  
COUNTY OF \_\_\_\_\_

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

My commission expires: \_\_\_\_\_

\_\_\_\_\_  
Signature of Notary Public



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[www.bcbst-medicare.com](http://www.bcbst-medicare.com)

A health plan with a Medicare contract.

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