ADVANCE CARE DIRECTIVE REGARDING DEMENTIA

9/27/2019

I, ______________________, of __________________________________ , am mentally and physically sound. I am under no constraint, duress, or undue influence. I have carefully considered the issues involved in this Advance Care Directive Regarding Dementia.

It is my desire that this document be a supplement to the Illinois Short Form Power of Attorney for Heath Care executed by me on ___________________, and to any Power of Attorney for Health Care or other advance care directive signed by me in the future. This Directive shall be part of my permanent medical records.

It is my legal right to direct my medical care and to refuse or discontinue any and all types of medical care and treatments. I interpret this to include the right to discontinue nutrition and hydration.

I have prepared and signed this Directive to make my wishes clear and to set forth the values and goals that are important to me. It is my desire that my agents under my Power of Attorney for Health Care and any other surrogate decision maker for me use this Directive as the basis for any decisions they make regarding my care in the situations described herein. It is my intent to empower my agents to honor and implement my wishes, and to remove any sense of guilt for following my wishes.

Dementia is a horrible, debilitating, incapacitating, progressive fatal disease. Dementia is an irreversible and incurable disease. Although the medical community is working to find a cure, there is no silver bullet on the horizon. As the disease progresses, my ability to recall my life's experiences and those that I love will fade away. I will lose my ability to communicate effectively, to process information, to take care of myself and to live independently. The advancing dementia will result in the loss of a meaningful existence and a loss of dignity that I find unacceptable. With this Directive, I am making my wishes known while I still have the ability to determine the appropriate levels of care and treatment goals if I become afflicted with dementia in the future.

I want to control my own fate. I want a gentle and peaceful death. I want to determine the character of the memories of my family and friends after my death.

The quality of my life is more important to me than the length of my life. I do not want the period before my death to be unnecessarily extended, to be emotionally or physically painful, or to include futile medical interventions.

I don't believe in miracles, and hope is not a justification for continued treatment. There is no benefit to letting dementia diminish me, and strip me of my existence and my humanity. If the writing is on the wall, please acknowledge it. Acting sooner is better, much better, than waiting too long. If I miss the "cure" by a week or a month, so be it.

Definitions

The following pages of this Directive include specific instructions for my care when I am exhibiting certain conditions. The following definitions shall be the basis for any related determination of my condition and the appropriate level of care to be provided.

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STAGES OF DEMENTIA

The directives and choices contained herein are based on the stages of dementia, substantially described as follows:

Mild Cognitive Impairment. This condition is characterized by relatively minor episodes of increased forgetfulness, trouble solving problems, and poor decision making. Mild Cognitive Impairment is not a form of dementia, and may not evolve into dementia.

Mild Dementia. Mild dementia is characterized by two or more impairments that significantly interfere with everyday life, including trouble with short-term memory and retaining new information, misplacing items (phone in the freezer), confusion, a failing sense of time or direction, and changes in mood or personality.

Moderate Dementia. Moderate dementia is characterized by serious cognitive issues and functional problems, including trouble recognizing family and friends, thinking it's a different time or place, trouble following simple conversations and instructions, loss of impulse control, needing assistance with activities of daily living, hallucinations and delusions, and some loss of bladder control.

Severe Dementia. Severe dementia is characterized by profound memory deficits, including the inability to recognize family and to communicate with others, and being completely dependent on others, including the inablity to perform the ADLs and to walk, and difficulty or inability to chew and swallow.

LEVELS OF CARE

The directives and choices contained herein are based on the goals and levels of medical care and treatment, substantially described as follows:

Aggressive Care. I want to live as long as possible, without concern for the quality of my life. I want all types of care and life sustaining treatments that may extend my life, including CPR, intubation, respirator/ventilator, feeding tube, IV hydration and dialysis.

General Care. I want all medical care and treatments which are likely to maintain or to return me to an acceptable quality of life, which includes the ability to communicate effectively, to process information, to remember, and to experience joy.

Limited Care. I acknowledge that my life has diminished and I want to be allowed to die a natural death. I want medical care and treatments which are likely to maintain an acceptable quality of life; however, I authorize and direct my agent to enter a Do Not Resuscitate order, to enter a Do Not Hospitalize order, and to direct the deactivation or removal of any devices which are artificially maintaining my life.

Comfort Care. I wish to forego all measures to prolong my life. I want to be comfortable. I want to receive medications for the relief of any signs of anxiety, agitation, insomnia or pain, in sufficient dosages and frequency to assure the effective relief of suffering, even though such medication might shorten my life. I want my lips and the inner surfaces of my mouth be kept moistened to minimize discomfort.

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Advance Care Directives

If my condition can be best described as **Mild Cognitive Impairment**, I direct my agent as follows:

LEVEL OF CARE

☐ **Agressive Care**. I want to live as long as possible, without concern for the quality of my life.

☐ **General Care**. I want all medical care and treatments which are likely to maintain or return me to an acceptable quality of life.

☐ **Limited Care**. I acknowledge that my life has diminished and I want to be allowed to die a natural death.

☐ **Comfort Care**. I wish to forego all measures to prolong my life. I want to be comfortable and to receive medications as necessary to relieve my suffering.

NUTRITION AND HYDRATION

If I can feed myself,

☐ I want to be allowed to feed myself, OR

☐ I want my agent to withdraw all nutrition and hydration.

If I cannot feed myself,

☐ I want a feeding tube, IV hydration, or other means of mechanical ingestion, OR

☐ I want to be spoon fed, if I appear to enjoy it and if I can chew and swallow, OR

☐ I want all nutrition and hydration to be withdrawn, even if I can chew and swallow.

★ ★ ★ ★

If my condition can be best described as **Mild Dementia**, I direct my agent as follows:

LEVEL OF CARE

☐ **Agressive Care**. I want to live as long as possible, without concern for the quality of my life.

☐ **General Care**. I want all care and treatments which are likely to maintain or return me to an acceptable quality of life.

☐ **Limited Care**. I acknowledge that my life has diminished and I want to be allowed to die a natural death.

☐ **Comfort Care**. I wish to forego all measures to prolong my life. I want to be comfortable and to receive medications as necessary to relieve my suffering.

NUTRITION AND HYDRATION

If I can feed myself,

☐ I want to be allowed to feed myself, OR

☐ I want my agent to withdraw all nutrition and hydration.

If I cannot feed myself,

☐ I want a feeding tube, IV hydration, or other means of mechanical ingestion, OR

☐ I want to be spoon fed, if I appear to enjoy it and if I can chew and swallow, OR

☐ I want all nutrition and hydration to be withdrawn, even if I can chew and swallow.

____
signature

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Advance Care Directives

If my condition can be best described as **Moderate Dementia**, I direct my agent as follows:

LEVEL OF CARE

- ☐ **Agressive Care**. I want to live as long as possible, without concern for the quality of my life.
- ☐ **General Care**. I want all medical care and treatments which are likely to maintain or return me to an acceptable quality of life.
- ☐ **Limited Care**. I acknowledge that my life has diminished and I want to be allowed to die a natural death.
- ☐ **Comfort Care**. I wish to forego all measures to prolong my life. I want to be comfortable and to receive medications as necessary to relieve my suffering.

NUTRITION AND HYDRATION

If I can feed myself,

- ☐ I want to be allowed to feed myself, OR
- ☐ I want my agent to withdraw all nutrition and hydration.

If I cannot feed myself,

- ☐ I want a feeding tube, IV hydration, or other means of mechanical ingestion, OR
- ☐ I want to be spoon fed, if I appear to enjoy it and if I can chew and swallow, OR
- ☐ I want all nutrition and hydration to be withdrawn, even if I can chew and swallow.

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If my condition can be best described as **Severe Dementia**, I direct my agent as follows:

LEVEL OF CARE

- ☐ **Agressive Care**. I want to live as long as possible, without concern for the quality of my life.
- ☐ **General Care**. I want all care and treatments which are likely to maintain or return me to an acceptable quality of life.
- ☐ **Limited Care**. I acknowledge that my life has diminished and I want to be allowed to die a natural death.
- ☐ **Comfort Care**. I wish to forego all measures to prolong my life. I want to be comfortable and to receive medications as necessary to relieve my suffering.

NUTRITION AND HYDRATION

If I can feed myself,

- ☐ I want to be allowed to feed myself, OR
- ☐ I want my agent to withdraw all nutrition and hydration.

If I cannot feed myself,

- ☐ I want a feeding tube, IV hydration, or other means of mechanical ingestion, OR
- ☐ I want to be spoon fed, if I appear to enjoy it and if I can chew and swallow, OR
- ☐ I want all nutrition and hydration to be withdrawn, even if I can chew and swallow.

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signature

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Additional Directives

If it does not impose an unreasonable burden on my family, I prefer to live and die at home, rather than in an institutional setting.

If I am admitted to an institution that will not honor my wishes for any reason, including policies based on the ethical or religious views of the institution, then my admission shall not be deemed to be a consent to such policies, and my agent is directed and authorized to move me to an institution that will honor my wishes, or to move me home for hospice or palliative care, notwithstanding any contrary advice regarding my discharge.

If I am (a) in a condition of permanent or near permanent unconsciousness or (b) in an irreversible condition with a minimal level of consciousness and the complete or nearly complete loss of the ability to think or communicate with others, then I want all life support systems and devices, including nutrition and hydration, to be withdrawn and I want to be allowed to die.

If I am afflicted with dementia, I hereby authorize my agent and health care surrogates to autopsy my brain and to donate my brain for educational or research purposes.

If I have lost the cognitive ability to personally address my situation, I want these expressed wishes to be binding. Any modification or revocation of this Directive shall be effective only if done when I am competent, and by a writing executed with the same formalities attendant upon the execution of this Directive.

Further, I hereby waive my legal right pursuant to Section 4-6 of the Illinois Power of Attorney Act to revoke or amend my Power of Attorney for Health Care, if at the time of any such attempted revocation or amendment a physician taking care of me determines that I do not have the ability to make health care decisions for myself.

Date: _______________________

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signature

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WITNESS:

The person who signed this Advance Care Directive (the "principal") is personally known to me. The principal appeared to me to be of sound mind, and acting of his own free will.

I am at least 18 years old. (check one of the options below):

☐ I saw the principal initial and sign this document,

or

☐ the principal told me that the initials and signature or mark on the principal signature line are his or hers.

I am not the agent or successor agent(s) named in the principal's Power of Attorney for Health Care. I am not related to the principal, such agent, or the successor agent(s) by blood, marriage, or adoption. I am not the principal's physician, advanced practice nurse, dentist, podiatric physician, optometrist, psychologist, or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the health care facility where the principal is a patient or resident.

Witness printed name: ____

Witness address: ____

Witness signature: ____

Today's date: ____

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