ADVANCE DIRECTIVE
DEMENTIA PROVISION

This Advance Directive Dementia Provision is made by:

Name:

____

Address:

____

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I make this Dementia Provision to inform my healthcare providers, loved ones, and healthcare representative (power of attorney, proxy, surrogate) of my treatment instructions in the event I lack capacity to give instructions myself. I am fully competent at this time. I have a separate, general advance directive in place. I ask that my general advance directive be maintained in my patient chart and applied according to its terms and that it be supplemented by this Dementia Provision.

I have also completed a legal form to appoint a healthcare representative and trust my representative to demand that my general advance directive be enforced in circumstances where it applies, and this Dementia Provision be enforced in the circumstances where it applies.

This Dementia Provision should be applied when my dementia has progressed to the point at which, in the opinion of my healthcare representative, I do not recognize my family members, loved ones, and friends; I cannot remember their names; or I am not able to communicate well enough to make clear whether I recognize my friends and loved ones or remember their names. I will call this "My Chosen End Point." I would wish to die quickly and peacefully under any of those circumstances.

At My Chosen End Point, I wish to receive the best available palliative and hospice care and refuse any medical treatment that would serve only to postpone my death, including, for example, vaccines, antibiotics or other antimicrobial drugs, antiarrythmics, cardiopulmonary resuscitation, blood transfusions, or any artificial or mechanical means of life support. I do not wish to extend my life or prolong the dying process.

At My Chosen End Point, I wish to be allowed to die by VSED, or the voluntary stopping of eating and drinking. I do not want to be encouraged, persuaded, or forced to eat or drink. I do not want food or fluid to be held near my mouth to provoke me to open my mouth reflexively. I ask that the scent of food not be present in my room. I instruct that I not be hand fed or hydrated unless, in my representative's view, the lack of hand feeding and hydration appear to cause me physical or emotional distress and I affirmatively appear to seek to be hand fed or hydrated to relieve the distress. Any palliative or sedative medication should not be given orally, if possible. Moistening of my lips to keep them comfortable is allowed.

I insist that nothing I do be deemed a revocation of this Dementia Provision unless I revoke it in writing at a time when I have the mental capacity to make and revoke an advance directive. In my view, hand feeding and hydration are forms of medical treatment and require the patient's consent. Today, while I am competent, I insist that I be allowed to die naturally by not eating or drinking at My Chosen End Point. Given that any other advance directive signed while I am competent is honored after I lack capacity, even if I would die as a result, there is no reason for my instructions regarding hand feeding and hydration to be treated differently.

I intend that my healthcare representative alone be the one to determine whether I have reached My Chosen End Point. I authorize my healthcare representative to take any legal action necessary to enforce my choice to die from VSED if I have reached My Chosen End Point.

I ask that any healthcare institution providing treatment for me maintain my advance directives in my chart and document prominently that these advance directives are in place, as required by 42 U.S.C. § 1395cc(a)(1)(Q) and (f), 42 U.S.C. § 1395i-3(c)(1)(E), and any applicable state law. I ask that the healthcare institution's management review these documents and determine if the healthcare institution has any policy against the enforcement of their terms. If so, I ask that I be transferred to an appropriate healthcare institution that does not have such a policy.

Signed,

____

Dated on ____________________, 20______

We, the following witnesses, testify that we know the signer of this document and believe, based on our experience, the signer is competent to make the decisions reflected herein.

WITNESS NO. 1:

Address:

__________________________________ __________________________________

Signature

__________________________________ __________________________________

Name written legibly

WITNESS NO. 2:

Address:

__________________________________ __________________________________

Signature

__________________________________ __________________________________

Name written legibly

THE NOTARY FORM ON NEXT PAGE
NEED NOT BE USED EXCEPT IN STATES WHERE
A NOTARIZATION IS REQUIRED

STATE OF ______________________________)

COUNTY OF ____________________________)

The foregoing instrument was acknowledged before me this ________ day

of _________________, 202________, by ______________________________
(Patient's name, legibly written)

_____________________________. The signer:

(Notary must check one)

_______ is personally known to me, or

_______ or produced ______________________________________

______________________________ as identification.

____
(Signature of Notary Public)

____
(Print, Type, or Stamp Commissioned Name of Notary Public)