Advance Health Care Directive Form

PRINT

Date ____ DAY ____ MONTH ____ YEAR

Date of birth ____ DAY ____ MONTH ____ YEAR

Medicare# _____

This is my Health Care Directive:

Name _____

Address _____ City _____

Province _____ Postal Code _____

Tel. _____ Cell _____

☐ **I revoke any previous health care directives**

Part 1 – Appointment of a Health Care Proxy (optional)

I appoint the following person to act as my proxy to make health care decisions if I am not capable:

Proxy: Name _____

Address _____ City _____

Province _____ Tel. _____ Cell _____

If my proxy is unable, unwilling or unavailable to make a health care decision, I appoint the following persons to act as as my alternate proxy:

Alternate Proxy: Name _____

Address _____ City _____

Province _____ Tel. _____ Cell _____

Alternate Proxy: Name _____

Address _____ City _____

Province _____ Tel. _____ Cell _____

☐ **No Proxy Appointed**

I do not wish to appoint a proxy but have provided instructions for treatment decisions in Part 2.

A Health Care Directive is equally valid whether or not you use this form.

Part 2 – Treatment instructions

(Optional: skip this part if you do not wish to provide treatment instructions)

I give the following instructions to health care professionals and/or my proxies regarding the health care treatment I do or do not want to receive and the circumstance in which I want or do not want to receive it.

My proxy may make health care decisions on my behalf when I am unable to do so for myself:

☐ with no restrictions ☐ with restrictions as follows:

Part 3 – Values and beliefs

I provide the following statement of my values, beliefs and wishes in general terms to guide decision-making by health care providers and my proxy (if I chose to appoint a proxy).

Notification **(optional)** [Attach additional page if desirable]

If it is determined that I lack capacity to make a health care decision, and this health care directive comes into effect, I wish the following persons to be notified:

Name _____

Address_____ City _____

Province_____ Tel. _____ Cell _____

Name _____

Address_____ City _____

Province _____Tel. _____ Cell _____

Part 4 – Signature and date

Your advance health care directive is complete once you sign it in the presence of your witness. If you are unable to sign, a substitute may sign on your behalf. The substitute must sign in your presence and in the presence of a witness. The proxy or the proxy's spouse or common-law partner cannot be the substitute or witness.

Maker's Signature _____ Date [ ] [ ] [ ]
DAY MONTH YEAR

Name of substitute _____

Address _____

Tel. _____ Cell _____

Witness

The directive must be signed by a witness who is at least 19 years of age.

Name of witness _____

Address _____

Tel. _____ Cell _____

Witness Signature _____ Date [ ] [ ] [ ]
DAY MONTH YEAR

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