Advanced Medical Directive

An advanced medical directive empowers you to make choices for yourself. One day, you might not be able to express your wishes due to a medical condition.

An advanced medical directive specifies which medical treatments you want or do not want at the end of your life or in the event that you are no longer able to make decisions on your own (e.g. in a coma or suffering from dementia).

Generally, an advanced medical directive describes certain life prolonging treatments. You, the declarant, indicate which treatment(s) you do or do not want given to you in the event you either suffer from an illness or are in a permanent vegetative state. **An advanced medical directive does not become effective unless you are incapacitated.** Implementation of an advanced medical directive usually requires a certification by **your doctor** and another doctor stating that you are either suffering from a life threatening illness or are permanently unconscious and unable to convey your wishes about your treatment. An advanced medical directive is ONLY used when your condition is such that your illness prevents you from understanding and signing the directives of the doctor regarding your condition.

In such a situation, when death is imminent, and the use of life-prolonging procedures and "heroic measures" would serve only to artificially prolong the dying process, by signing this document, you direct your designated appointee(s) to withhold or implement such measures. Before those situations arise, you are able to state what treatments you do or do not want.

Section 16 of the Law of Patients Rights states that each patient can decide for himself or herself what treatments he or she wishes to receive or not to receive.

If you make a properly signed advanced medical directive, this will eliminate the need for your family to go to court for a power of attorney (apotropus) if you are hospitalized and are not able to convey your wishes. The advanced medical directive that you sign shall eliminate any questions about what you want your end-of-life treatment to be.

This directive is for medical purposes ONLY. There is no connection between this document and any other document that involves your personal property. If there is a person who has a general power of attorney involving your property, that person is NOT automatically designated to have a medical power of attorney. A person must be **specifically designated** as your attorney for medical matters.

None of these documents will help you if no one knows about them. You must speak with your doctor(s) and the person(s) you have designated to act as your medical power of attorney. Discuss what types of end-of-life medical treatments you want. He or she can be helpful in answering any questions you may have about certain treatments. Once you have decided what it is you do or do not want, make your wishes known to your doctor and to your family. Be certain that a signed copy of this document is being held by you, by the person or persons whom you have designated as power of attorney, your lawyer if you have one, and by your doctor. A copy of your advanced medical directive should be placed in your hospital file if you are admitted to the hospital.

This document does not apply to people who are diagnosed with a terminal illness (terminal illness is defined as a life span of no more than six months). Those people must sign another document according to the law.

IT IS IMPORTANT THAT YOUR WISHES BE HONORED and only by having a signed advanced medical directive will may your wishes be known.

Power of Attorney for Medical Treatment according to Section 16 of the Patients' Rights Law

1. I, the undersigned _____ _____
Name I.D.

of _____
Full Address

Phone: _____ Cell Phone: _____

Hereby appoint _____ _____
Name I.D.

of _____
Full Address

And/or _____ _____
Name I.D.

of _____
Full Address

(It is not obligatory to appoint two)

to represent me by this power of attorney.

1. If there is a difference of opinion between the appointees, the decision of the first appointee shall be implemented. If the first appointee is not available at the relevant time, the decision of the second appointee will be implemented.

2. This power of attorney shall come into force in the event that my consent shall be required for medical treatment, and at that time, I am not competent to give my consent due to my physical or mental condition.

3. This power of attorney shall be effective for the following matters: (mark by X in the appropriate place).

   □ To agree or to refuse in my name any medical proceeding and treatment that I shall require, including treatment that requires

written consent.

☐ To agree or to refuse in my name the medical treatments listed hereafter only:

☐ Surgery

☐ Resuscitation

☐ Treatment for relieving pain

☐ Artificial alimentation (feeding tube)

☐ Connection to a respirator

☐ All life-prolonging treatments

☐ Chemotherapy

☐ Dialysis

☐ Others: please detail _____

☐ Request and receive medical information and/or medical opinion from any caregiver/ medical institution where I have been treated or am being treated when this information is necessary for a decision regarding my treatment.

☐ To decide to hospitalize me in a medical institution or long term care institution including chronic hospitalization, subject to the provisions of any law, or with the following reservations:_____

☐ To represent me before the Ethics Committee according to the Patients' Rights Law, if necessary.

☐ To give my consent to other additional accompanying actions connected to medical treatment.

4. For the sake of avoiding doubt, my attorney shall not be entitled to perform in my name any financial action or financial undertaking.

The is not entitled to waive, in my name, medical confidentiality, except if this is essential for the medical treatment that I require and in respect to which he is required to decide as my attorney.

5. Additional conditions and limitations of the power of attorney:

_____

_____

_____

_____

6. This power of attorney does not constitute a waiver of my rights, and I shall be entitled to cancel the appointment at any time by giving a written notice to the attorney, or to the caregiver, or to any medical institution where a copy of this power of attorney is kept, respectively. In special circumstances in which it is not possible to receive a written notice from me, I may cancel the power of attorney orally before two witnesses, provided that my words and the testimony shall be documented in writing as soon as possible afterwards.

7. I hereby exempt my appointee(s) from liability for the results of using the power of attorney and anyone else who shall act on the basis of this power of attorney, provided that they acted in good faith.

8. In addition to this power of attorney:

☐ I have also signed a power of attorney in keeping with the Dying Patient's Law.

☐ I have given preliminary instructions.

9. This power of attorney shall expire within ten years from today.

And in witness whereof, I have signed, with clear mind, out of my own free will and without any pressure or coercion.

Date _____

Location _____

_____

Signature

Consent of Attorney

I, the undersigned

Name_____ Identity no. _____

Tel:_____ Cell phone: _____\

Name_____ Identity no. _____

Tel:_____ Cell phone: _____\

Agree to be appointed as attorney for the above mentioned patient with respect to medical treatment as set forth above, after having read this power of attorney and understanding my role and authorities.

I am aware that I must clarify in advance, insofar as possible, the wishes of the patient regarding medical treatment in different situations, and to faithfully fulfill the wishes of the patient. I am aware that my discretion and ability to act are limited to the issues mentioned in this power of attorney, and subject to the patient's instructions insofar as they were given to me in advance, and to the patient's benefit.

Date_____Signature of Attorney_____

Date_____Signature of Attorney_____

Signature of the verifying witness (doctor/ social worker/ nurse/ psychologist/ lawyer)

I hereby confirm that the above-named person(s), signed before me on this document of power of attorney, after I have confirmed their identity to the best of my ability, and in the belief that they understand the meaning of the document, are my representatives.

Date_____

Stamp_____ Signature _____

General Comments:

The appointer and the attorney(s) must be adults, clear minded and able to understand the meaning of the appointment. A minor, and whoever is not able to give informed consent for any reason, cannot appoint an attorney for himself and he is not competent to be appointed as an attorney.

The patient must receive the attorney's consent to the appointment.

It is possible to appoint more than one attorney, partners or substitutes. It is not advisable to appoint two joint attorneys, however if they were appointed this way – this must be mentioned and provisions must be set out in the power of attorney regarding cooperation between them, decision in disputes and how to act in the event that one of them is not available.

The relevant parties must be informed of the existence of the power of attorney according to need, such as at the time of hospitalization, or at the time of placement in an institution. It is advisable to deposit copies of the power of attorney with the treating doctors.