Advance Medical Directive Work-Sheet Template

I. Personal Details

1. **Personal Statement**

   ☐ I am completing this Advance Medical Directive -AMD (Living Will) of my own free will and with full understanding of what AMD means and with clarity on its implications**.**

2. **Personal details. Use BLOCK LETTERS**
   - **2.1. Full Name (Given Name and Surname):**
   - **2.2. Date of Birth:**
   - **2.3. Age:**
   - **2.4. Gender:**
3. **Proof of Identity[1] (Aadhar Card details).**
4. **Address**
5. **Phone Number:**
6. **Email (optional):**
7. **Signature, Date, Place:**

II. My Medical Decision-Maker(s) (Surrogate)

1. **Statement with regard to my medical decision maker when I am unable to decide for myself**

   ☐ I want Following person to make my medical decisions if I am unable to make them myself.

   ☐ My medical decision-maker will act only when I am unable to make or communicate my own medical decisions.

2. My medical decision-maker/ **Surrogate** will:
   - 2.1. Speak and decide on my behalf based on the wishes, preferences, and refusals I have written in this document.
   - 2.2. Work with my family, doctors, and hospital team to make sure my voice is heard and respected.
   - 2.3. Not handle my financial, legal, or property matters, or receive any payment for this role.
   - 2.4. Step down if I choose to revoke or change this appointment in the future.
   - 2.5. Clarify with my treating doctors the best and worst scenarios with and without the intervention under consideration, and reflect on my values and preferences, before deciding that **the intervention is, or is not applicable and not in my best interests**.

3. I choose the following person/s to make medical decisions for me if, at any time, I am too unwell to make medical-decision choices for myself. *(* You may either choose to record their names and contact details only; or have them read and sign on this document- as per feasibility)*

   3.1. **Primary Decision-Maker 1**

[1] ***Government of India List of Acceptable Proofs of Identity and Address***

Full Name (Given Name and Surname): _____
Date of Birth: _____
Relationship to You: _____
Proof of Identity: ☐ Aadhaar Card ☐ Voter ID ☐ Passport ☐ Driving Licence ☐ PAN Card

ID Number: _____

Address (Present / communication) _____

City: _____ **State:** _____**PIN:** _____
Phone Number: _____**Email (optional):** _____

☐ I have read and understood the wishes expressed in this Advance Medical Directive.

☐ I agree to act as the nominated medical decision-maker(s) and to uphold these values and choices to the best of my/our ability, in discussion with the treating doctors, the family and palliative care specialists as required.

Signature of acceptance by the appointed decision maker: Date:

3.2. **Primary Decision-Maker 2**

Full Name (Given Name and Surname): _____
Date of Birth: _____
Relationship to You: _____
Proof of Identity: ☐ Aadhaar Card ☐ Voter ID ☐ Passport ☐ Driving Licence ☐ PAN Card

ID Number: _____

Address (Present / communication) _____

City: _____ **State:** _____**PIN:** _____
Phone Number: _____**Email (optional):** _____

☐ I have read and understood the wishes expressed in this Advance Medical Directive.

☐ I agree to act as the nominated medical decision-maker(s) and to uphold these values and choices to the best of my/our ability, in discussion with the treating doctors, the family and palliative care specialists as required.

Signature of acceptance: Date:

3.3. <u>Alternate Medical Decision-Maker</u>

If both the persons named above are unable or unwilling to act, any adult member of my family may assist the treating team in expressing my wishes regarding treatment, as recorded in this Directive.

Full Name (Given Name and Surname): _____
Date of Birth: _____

Relationship to You: _____

Proof of Identity: ☐ Aadhaar Card ☐ Voter ID ☐ Passport ☐ Driving Licence ☐ PAN Card

ID Number: _____

Address (Present / communication) _____

City: _____ **State:** _____**PIN:** _____

Phone Number: _____**Email (optional):** _____

☐ I have read and understood the wishes expressed in this Advance Medical Directive.

☐ I agree to act as the nominated medical decision-maker(s) and to uphold these values and choices to the best of my/our ability, in discussion with the treating doctors, the family and palliative care specialists as required.

Signature of acceptance: Date:

4. **I record my preferred options which I wish to be respected, if and when I become very sick and may not recover –** (Mark with a ✓ next to those options that applies to your directive)
   - ☐ I want all life-support treatments that my doctors think might help. Even if there is little chance of getting better, I want to continue life support — even if it causes discomfort or suffering.
   - ☐ I want my doctors to try life-support treatments that might help. But if the treatments don't work and there is little hope of recovery, I do not want to stay on life-support machines. If I am suffering, I want treatment to focus on my comfort.
   - ☐ I do not want life-support treatments initiated. I prefer care that keeps me comfortable and allows a peaceful and natural death.
   - ☐ I want my medical decision-maker (Surrogate) to decide about relevance of life-support treatments for me, after due reflection on my values, preferences and considering the the pros and cons of the opinions with my doctors (as explained in 2.5).

5. **I record below the flexibility that my medical decision-maker have in following my priorities, wishes** (Mark with a ✓ next to the option that best matches your wishes).

   - ☐ **Total flexibility** — It is okay for my medical decision-maker to change my medical decisions if my doctors believe it would be in my best interest at that time.
   - ☐ **No flexibility** — I want my medical decision-maker to follow my medical wishes exactly as written, even if my doctors suggest a different approach.
   - ☐ **Some flexibility** — It is okay for my medical decision-maker to change some of my decisions if my doctors feel it would help me.
   - ☐ However, the following are my wishes which are non-negotiable:

     _____

     _____

III. My Priorities, Choices and Wishes (Place a ✓ next to the choice that best describes your wishes)

I note down my choices so that those who care for me may be guided. Following are what makes my life meaningful and worth living.

1. **"My life is only worth living if it allows me to** (Mark with a ✓ next to options that matter to you)

   ☐ Talk to my family or friends
   ☐ Wake up and be aware of what is happening around me
   ☐ Feed, bathe, or take care of myself
   ☐ Be free from pain or severe suffering
   ☐ Live without being dependent on machines to stay alive
   ☐ My life is always worth living, no matter what
   ☐ I am not sure now; I leave it to my surrogate to decide

2. **"If I am seriously ill or dying, it is important for me to be…"** Mark with a ✓ next to options that matter to you)
   ☐ At home, whether medical, nursing help is available or not.
   ☐ At a setting where pain relief, symptom management and comfort care are prioritised
   ☐ Hospital ☐ Hospice ☐ Home-based palliative care

3. **I record the Importance that I give to my religious and / or spiritual leanings as**
   ☐ Not Important at all
   ☐ Yes, it is important

   My religion or faith is: _____

   I would like my doctors to know the following about my religious or spiritual beliefs or practices (write down what is most important according to your religious belief)

   _____

   _____

4. **I wish list those aspects that has and continue to give my life meaning, purpose and peace** *(For example: completion of my duties, time with loved ones, being with nature, music, prayer, Eco friendship, human connections, my work, contributing to the community, helping others, learning, my legacy, family traditions, personal practices towards my Supreme ideal etc.)*

   _____

IV. <u>Optional</u>: Other Wishes which are very important for me, after my death, that I'd like to record right now.

1. **Organ Donation** (Put a ✓ next to the choice that best describes your wishes)

   ☐ Any organ ☐ Eyes ☐ _____

   ☐ I do not wish to donate any of my organs.
   ☐ I want my medical decision-maker (Surrogate) or family to decide.

2. **Donation of my Body for Medical Education and Research**

   You can also choose to **donate your entire body** after death to a medical college for education and research. Put a ✓ next to the choice that best describes your wishes:

   ☐ I wish to donate my body for medical education or research.
   ☐ I do **not** wish to donate my body.
   ☐ I wish my medical decision-maker or family to decide.

3. **Other wishes that are very important to me are**

   _____

_____

V. Signed Declaration by the Executor, Witnesses & Attestation of the AMD

1. Declaration (Mark with a ✓ next to **all** the options)

☐ I, _____ am of sound mind and am making this Directive voluntarily, without pressure, coercion, or influence from anyone.
☐ I declare that I have read and understood this Advance Medical Directive.
☐ I confirm that all the information I have provided in this document is true and correct to the best of my knowledge and belief.
☐ I understand that this document will come into effect only if I become unable to make or communicate my own medical decisions.

Aadhar Card Number Father's Name:

Signature: _____ Date/ time/ place: _____

2. Witnesses

Witness 1

☐ I confirm that I have signed this document as independent witness, in the presence of the executor of this living will, who appeared to be of sound mind and acted voluntarily, without coercion, at the time of executing her/his living will (AMD)

Full Name (Given Name and Surname): _____

Age/Date of Birth: _____

Aadhar Card Number_____

Address: _____

City: _____ State: _____ PIN: _____

Phone Number: _____ Email (optional): _____

Signature: _____ **Date/ time/place:** _____

Witness 2

☐ I confirm that I have signed this document as independent witness, in the presence of the executor of this living will, who appeared to be of sound mind and acted voluntarily, without coercion, at the time of executing her/his living will (AMD)

Full Name (Given Name and Surname): _____

Age/Date of Birth: _____

Aadhar Card Number_____

Address: _____

City: _____ State: _____ PIN: _____

Phone Number: _____ Email (optional): _____

Signature: _____ Date/ time/place: _____

VI. Attestation by Notary Public / Gazetted Officer

☐ I have verified the identity, free will, and mental capacity of the person making this Advance Medical Directive (living Will) and attest this document accordingly. I have verified the identity of both the witnesses, and they have signed this document in my presence.

Signature of the Attesting Officer: _____

Full Name: _____

Designation: Notary Public/ Gazetted Officer _____

Office Address: _____

Seal/Stamp: _____Date/time/ place: _____

VII. **I confirm that my signed notarised Living Will is duly authenticated, activated through the following** (Mark with a ✓ next to the options)

☐ **I have shared my signed notarised Living Will by Email to the Custodian relevant to my Residencial Address on __/__/___. The Email address of the Custodian is**

_____

☐ **I have shared copies of my signed notarised Living Will with all my listed surrogate decision makers**

☐ **I have shared copies of my signed notarised Living Will with my doctor/s, whose details are given below**

_____

_____

_____

Explanations

I. General Information

- A Living Will or the Advance Medical Directive (AMD) is a written form in which you **express your wishes about how you would like to be treated medically if, in the future, you become too sick to decide or speak for yourself.** An **AMD** lets you plan ahead by writing down your wishes for care, including what treatments you want or wish to avoid.
- Your AMD will come into effect **only if and when you become unable to make or communicate your own medical decisions.**
- It helps your loved ones and doctors understand your values and make decisions that respect your choices, reducing confusion or guilt later. It spares your family and doctors from having to guess what you would have wanted when you are unable to communicate.
- You may revoke, modify, or redo your AMD at any point of time.
- The most recent AMD will be considered as the valid one.
- To be thorough, you can attach a medical certificate confirming your mental capacity, dated close to the date of execution of the AMD.
- **For your AMD (living Will) to be valid**, it should be notarised AND be submitted to the custodian appointed by the state authority, assigned as per your residential address AND / OR be uploaded in your digital health record.
- Your AMD should be informed, and copies of the notarised AMD should be given to your nominated medical decision-maker (surrogate), close relatives, and also to your personal physician.
- If a situation arises where you are too unwell to share what you want, the treating physician shall ascertain the genuineness, authenticity of the AMD thereof, by referring to the digital health records OR from the Custodian office.
- You are allowed to modify or revoke your AMD / living will at any time.
- When there are multiple, the latest recorded AMD / living will be considered as valid.

II. My Medical Decision-Maker(s) (Surrogate)

- You should specify the of the person/ s (called the surrogate, medical decision-maker, or health-care proxy), who will make decisions on your behalf when you are unable to do so.
- This could be your relative, guardian, friend, family physician, or others, who are > 18 years of age, who understands your health, values, and what matters most to you; whose judgement you trust; and who is willing and available to speak on your behalf when needed; and can make decisions in good faith and communicate them in your best interests.
- Your Surrogate should base decisions on the values, priorities, and understanding of what you consider a meaningful quality of life, as described in this document.
- You may choose more than one person as decision-maker. The precedence order will be as per the listed order.
- **What will happen if I don't choose a medical decision maker?**
    - If you become too sick to make your own decisions, your doctors will ask your family or friends, but they may not know what you want.
    - You should inform & share a copy of your AMD with the named medical decision makers
- **What kind of decisions can my medical decision-maker make?**

- Your medical decision-maker can agree to, say no to, change, stop, or choose:
- • Your doctors, nurses, the hospital, clinic, or place where you receive care, Medications, tests, or treatments and what happens to your body or organs after your death
- By completing this form, you appoint someone you trust to make medical decisions only when you are unable to do so yourself. This authority does not cover financial or business matters. It is essential that you discuss your wishes with your Surrogate, so they clearly understand your preferences and are willing to uphold them when needed. Ideally, your Surrogate should also sign this form to confirm acceptance of this role.
- Copies of this notarised AMD should be given to your nominated medical decision-maker, close family members, and your personal physician

III. Personal Healthcare Choices

*The **resuscitation process** can be **physically intense and sometimes painful**, and it **may or may not be successful.** Its outcome **depends on your age, overall health, and existing medical conditions**. In many serious or advanced illnesses, CPR and other resuscitation measures may not bring a person back to meaningful recovery.*

You are encouraged to discuss with your doctor whether CPR or other life-support measures would be beneficial for you at your current stage of illness before recording your choice in this form.

- **Life-Support Treatments**
  I. CPR (Cardiopulmonary Resuscitation)
  II. Breathing Machine (Ventilator):
  III. Dialysis
  IV. Feeding Tube
  V. Blood Transfusions
  VI. Artificial support for heart functions
  VII. High-risk surgical interventions
  VIII. Chemotherapy, immunotherapy, other cancer-directed therapies
  IX. Other artificial intervention / devices used for the purpose of prolonging vital functions, which are not listed above

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1.1: CPR is an emergency treatment used when your heart or breathing stops. It may involve: Pressing hard on your chest to keep blood circulating; Giving electric shocks to restart your heart; Injecting medicines into your veins

1.2: A ventilator pumps air into your lungs when you cannot breathe on your own. You cannot talk or eat while on the machine.
1.3: A machine that cleans your blood if your kidneys stop working.

1.4: Provides nutrition and fluids when you cannot swallow, either through the nose or by a small surgery into the stomach.

1.5: Blood given through your veins to replace what your body needs.

1.6: Medicines given to artificially hold-up the heart rate, rhythm and / or blood-pressure

Explanations Continued…

1.7: Surgery where benefit is unsure, and serious harm is real

1.8: at terminal stage of life, oncological treatment may not add benefit but may add harm and poor quality of life.

General Recommendations on When Not to Consider Life-Support Treatments

- When your condition has reached a stage of no return, where the treatment-options are unable to modify your disease-course, enhance daily activities, nor improve how you feel day-to-day.
- When the suggested interventions would add to your burden of discomfort or prolong your suffering, rather than help you feel better.
- When you and your doctors decide that it is better for care to focus on comfort, dignity, and relief from distress rather than on machines or invasive treatments.
- When your treating doctors agree that continuing life-support is unlikely to help and may no longer be medically beneficial.

When Life-Support Treatments May Help You	**When Life-Support Treatments May Not Help You**
When your condition comes on suddenly and can possibly be reversed — for example, if your heart or lungs fail after surgery, because of an infection, or after an accident.	When your illness has reached an advanced stage and cannot be reversed — such as a cancer that has spread to many parts of the body or is no longer responding to treatment, severe dementia, or when several vital organs stop working.
When short-term treatments like a ventilator, dialysis, or IV medicines could give your body the support it needs to recover from a treatable condition.	When such treatments would only keep your body alive, but not your own idea or concept of "being alive" — for example, being aware, independent, and able to interact meaningfully.
When your organs are still strong enough to respond well to treatment.	When your organs have already stopped working beyond recovery, and life-support would not change the outcome.
When you want your doctors to use every possible medical option to try to keep you alive, even if it means being in intensive care.	When you prefer care that focuses on comfort, dignity, and relief from distress rather than intensive medical procedures.
When there is a real chance that you can recover and return to a meaningful life.	When recovery is unlikely, or surviving would mean being dependent on machines and living with continued suffering.
When these treatments match your own values, hopes, and goals for your life.	When these treatments go against your beliefs, wishes, or the way you would want to live.

IV. My Priorities, Choices and Wishes

As you are completing this part of the form, focus on your highest Values, what's most important to you even when you are semi/unconscious and unable to speak for yourself.

This section will guide your family / caregivers to make right choices on your behalf, beyond the medical technicalities.

V. Other Wishes that I'd like to record right now

- *Discuss this wish with your family as it may be difficult for them to decide about this on their own.*
- Donating (giving) your organs can help save or improve other people's lives.
  *In India, organ donation is regulated by the **Transplantation of Human Organs and Tissues Act, 1994** (and amendments). Final consent is usually confirmed by your family.*
- *Whether organ donation is possible depends on your medical condition, the cause and place of death, and hospital facilities. You can discuss your wish with your doctor or transplant coordinator, so it is clearly recorded in your medical file.*
- Donating (giving) your organs can help save or improve other people's lives.
  Put a ✓ next to the choice that best describes your wishes:
- *If you wish to donate your body, please inform your family and your primary doctor. Usually, the anatomy department of a nearby **medical college hospital** will have an official form to complete with the required consent and registration process.*

VI. Signed Declaration by the Executor, Witnesses & Attestation of the AMD

- To be thorough, you can attach a medical certificate confirming your mental capacity, dated close to the date of execution of the AMD
- This document must be witnessed by two independent persons who are not: your nominated medical decision-maker (Surrogate or Health-Care Proxy), nor your family member, nor your treating doctor, nurse, or any healthcare provider involved in your care.
- They witnesses should sign before the notary/gazetted officer

VII. Attestation by Notary Public / Gazetted Officer

- For your AMD (living Will) to be valid, the notarised AMD should be uploaded in your digital health record and / or submitted to the custodian appointed by the state authority, assigned as per your residential address.
- Your AMD will come into effect only if and when your treating doctors are fully satisfied that the condition is irreversible, terminal & that you are unable to make or communicate medical decisions
- When the executor is terminally ill, the treating physician shall ascertain the genuineness, authenticity of the AMD thereof, by referring to the digital health records OR from the Custodian office
- You are allowed to modify or revoke your AMD / living will at any time.
- When there are multiple AMDs, the latest recorded AMD / living will be considered as valid.