

# CONNECTICUT Advance Directive Planning for Important Healthcare Decisions

## *Caring Connections*

1731 King St., Suite 100, Alexandria, VA 22314

[www.caringinfo.org](http://www.caringinfo.org)

800/658-8898

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

## **It's About How You LIVE**

*It's About How You LIVE* is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

**L**earn about options for end-of-life services and care

**I**mplement plans to ensure wishes are honored

**V**oice decisions to family, friends and healthcare providers

**E**ngage in personal or community efforts to improve end-of-life care

## Using these Materials

### BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
  - Instructions for preparing your advance directive, please read all the instructions.
  - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

### ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

## Introduction to Your Connecticut Advance Directive

This packet contains the *Connecticut Advance Directive for Healthcare* which protects your right to refuse medical treatment you do not want or to request treatment you do want in the event you lose the ability to make decisions yourself.

The **Connecticut Healthcare Instructions** let you state your wishes about medical care in the event you are terminally ill or are permanently unconscious and can no longer make your own medical decisions. The first part of this document is the *Living Will*. The Living Will becomes effective in the following situations:

- you have an incurable or irreversible medical condition which, without the use of life support, will result in death in a relatively short period of time, or
- you are in a permanent coma a persistent vegetative state, or other irreversible condition in which you are at no time aware of yourself or the environment and show no behavioral response to the environment.

The second part of the Connecticut Health Instructions is the *Appointment of a Healthcare Representative*. Your appointed representative will be asked to make life support decisions for you when you are unable to speak for yourself.

*Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).*

## **Completing Your Connecticut Healthcare Instructions**

### **How do I make my Connecticut Healthcare Instructions legal?**

The law requires that you sign and date your document in the presence of two adult witnesses who must also sign the document to show that you appear to be 18 years of age or older, of sound mind, and able to understand the nature and consequences of the healthcare decisions you make by signing the document. The person you appoint as your Healthcare representative cannot serve as a witness or sign the document.

If you are a resident of a facility operated or licensed by the Department of Mental Health and Addiction Services:

- at least one witness must be an individual who is not affiliated with your healthcare facility, and
- at least one witness must be a physician or clinical psychologist with specialized training in treating mental illness.

If you are a resident of a facility operated or licensed by the Department of Developmental Services:

- at least one witness must be an individual who is not affiliated with your treating healthcare facility, and
- at least one witness must be a physician or clinical psychologist with specialized training in developmental disabilities.

If you wish, you may also ask each witness to complete an additional form, called a Witness Affidavit (enclosed), which must be signed in front of a notary public or other officer authorized to administer oaths. This Affidavit may be included on your Connecticut Healthcare Instructions document, or if that is impracticable, on some paper attached to the Connecticut Healthcare Instructions. If your Healthcare Instructions were ever challenged legally, the Witness Affidavit would be accepted by a court as evidence of the document's validity.

### **Whom should I appoint as my Healthcare Representative?**

Your Healthcare Representative is the person you appoint to make all healthcare decisions for you if you are unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment, including the decision to withhold or withdraw life support. Your Healthcare Representative can be a family member or a close friend whom you trust to make serious decisions. The person you name as your Healthcare Representative should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you. (A representative may also be called a "proxy").

## Completing Your Connecticut Healthcare Instructions (continued)

The person you appoint as your Healthcare Representative **cannot** be:

- your attending physician,
- an operator, administrator or employee of a healthcare facility in which you are a patient or resident or to which you have applied for admission, unless he or she is related to you by blood, marriage or adoption, or
- an administrator or employee of a government agency that is financially responsible for your medical care, unless he or she is related to you by blood, marriage or adoption.

You can appoint a second person as your alternate representative. The alternate will step in if the first person you name as Healthcare Representative is unable, unwilling or unavailable to act for you.

*Note: You may revoke an appointment of health care representative in a writing signed by you and two witnesses. If you appoint your spouse as your Healthcare Representative, his or her power will be revoked if your marriage ends, unless you specify otherwise.*

### **Should I add personal instructions to my Healthcare Instructions?**

Yes. You can add personal instructions in the living will section of your document in the space marked "Other specific requests." If you have appointed a Healthcare Representative, it is a good idea to write the statement, "Any questions about how to interpret or when to apply my written instructions are to be decided by my Healthcare Representative."

It is important to learn about the kinds of life-sustaining treatment you might receive. Consult your doctor for more information.

### **What if I change my mind?**

You may revoke your Healthcare Instructions at any time and in any manner, regardless of your mental or physical condition. Once you notify your doctor or other healthcare provider of your revocation, he or she must make it part of your medical record.

## **Completing Your Connecticut Healthcare Instructions (continued)**

### **What other important facts should I know?**

- Due to restrictions in the state law, a pregnant patient's Healthcare Instructions will not be honored.
- You can also use your Healthcare Instructions to nominate the person you would want appointed as a conservator of your person. A conservator of the person is someone appointed by the Court to supervise the personal affairs of a person when the Court finds a person incapable of caring for himself/herself. The conservator has responsibility for the general custody and care of the individual and may give consent for medical care, treatment and services. If you have a conservator appointed to you, he or she will be consulted for all medical decisions; however, the conservator's consent is not required to carry out your wishes as expressed in your Healthcare Instructions.
- Your Connecticut Healthcare Instructions has an optional section that you can use to donate your organs.

INSTRUCTIONS

**THESE ARE MY HEALTH CARE INSTRUCTIONS, INCLUDING MY LIVING WILL, MY APPOINTMENT OF A HEALTH CARE REPRESENTATIVE, THE DESIGNATION OF MY CONSERVATOR OF THE PERSON FOR MY FUTURE INCAPACITY AND MY DOCUMENT OF ANATOMICAL GIFT**

LIVING WILL

**LIVING WILL**

To any physician who is treating me: These are my health care instructions including those concerning the withholding or withdrawal of life support systems, together with the appointment of my health care representative, the designation of my conservator of the person for future incapacity and my document of anatomical gift. If the time comes when I am incapacitated to the point when I can no longer actively take part in decisions for my own life, and am unable to direct my physician as to my own medical care, I wish this statement to stand as a testament of my wishes. As my physician, you may rely on any decision made by my health care Representative, or conservator of my person, if I am unable to make a decision for myself.

PRINT YOUR NAME

I, \_\_\_\_\_,  
(name)

the author of this document, request that, if my condition is deemed terminal or if I am determined to be permanently unconscious, I be allowed to die and not be kept alive through life support systems. By terminal condition, I mean that I have an incurable or irreversible medical condition which, without the administration of life support systems, will, in the opinion of my attending physician, result in death within a relatively short time. By permanently unconscious I mean that I am in a permanent coma or persistent vegetative state or other irreversible condition in which I am at no time aware of myself or the environment and show no behavioral response to the environment.

SPECIFIC INSTRUCTIONS

**Specific Instructions:**

Listed below are my instructions regarding particular types of life support systems. This list is not all-inclusive. My general statement that I not be kept alive through life support systems provided to me is limited only where I have indicated that I desire a particular treatment to be provided.

**CONNECTICUT HEALTH CARE INSTRUCTIONS – PAGE 2 OF 7**

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CHECK AND INITIAL  
THE OPTIONS THAT  
REFLECT YOUR  
WISHES

	Provide	Withhold
Cardiopulmonary Resuscitation	_____	_____
Artificial Respiration (including a respirator)	_____	_____
Artificial means of providing nutrition and hydration	_____	_____
_____	_____	_____
_____	_____	_____

ADD PERSONAL  
INSTRUCTIONS  
(IF ANY)

Other specific requests:

PAIN RELIEF

I do want sufficient pain medication to maintain my physical comfort. I do not intend any direct taking of my life, but only that my dying not be unreasonably prolonged.

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Palliative Care  
Organization  
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HEALTH CARE  
REPRESENTATIVE

APPOINTMENT OF HEALTH CARE REPRESENTATIVE

PRINT THE NAME  
AND PHONE  
NUMBER OF YOUR  
REPRESENTATIVE

I appoint \_\_\_\_\_,  
(health care representative)

\_\_\_\_\_, to be my health care representative  
(telephone number)

If my attending physician determines that I am unable to understand and appreciate the nature and consequences of health care decisions and unable to reach and communicate an informed decision regarding treatment,

\_\_\_\_\_, my health  
(health care representative)  
care representative is authorized

To make any and all health care decisions for me, including:

- (1) The decision to accept or refuse any treatment, service or procedure used to diagnose or treat my physical or mental condition, except as otherwise provided for by law such as for psychosurgery or shock therapy;
- (2) The decision to provide, withhold or withdraw life support systems;

I direct my health care representative to make decisions on my behalf in accordance with my wishes, as stated in this document or as otherwise known to my health care representative. In the event my wishes are not clear or a situation arises that I did not anticipate, my health care representative may make a decision in my best interests, based upon what is known of my wishes

**CONNECTICUT HEALTH CARE INSTRUCTIONS - PAGE 4 OF 7**

HEALTH CARE REPRESENTATIVE

PRINT THE NAME AND PHONE NUMBER OF YOUR ALTERNATE REPRESENTATIVE

If \_\_\_\_\_  
(health care representative)  
is unwilling or unable to serve as my health care representative, I appoint

\_\_\_\_\_  
(alternate health care representative)

\_\_\_\_\_  
(telephone number of alternate)

to be my alternate health care representative.

**DOCUMENT OF ANATOMICAL GIFT**

ANATOMICAL GIFT

I make no anatomical gift at this time. \_\_\_\_\_  
(Initial here)

CHECK AND INITIAL THE STATEMENTS THAT REFLECT YOUR WISHES

I hereby make this anatomical gift, if medically acceptable, to take effect upon my death. \_\_\_\_\_  
(Initial here)

- I give: (check one)  
\_\_\_\_\_ (1) any needed organs or parts  
\_\_\_\_\_ (2) only the following organs or parts

**List organs or parts to be donated**

- to be donated for: (check one)  
\_\_\_\_\_ (1) any of the purposes stated in subsection (a) of section 19a-279f of the general statutes  
\_\_\_\_\_ (2) these limited purposes

**List any purposes**

DESIGNATION OF  
CONSERVATOR OF  
THE PERSON

PRINT THE NAME  
AND PHONE  
NUMBER OF YOUR  
CONSERVATOR

PRINT THE NAME  
AND PHONE  
NUMBER OF YOUR  
ALTERNATE  
CONSERVATOR

SIGN AND DATE  
YOUR DOCUMENT

**DESIGNATION OF A CONSERVATOR OF THE PERSON**

If a conservator of my person should need to be appointed, I designate

\_\_\_\_\_, \_\_\_\_\_  
(conservator) (phone number of conservator)  
be appointed my conservator.

If \_\_\_\_\_ is unwilling or unable to serve as my  
(conservator)  
conservator,

I designate \_\_\_\_\_,  
(alternate conservator)  
\_\_\_\_\_.  
(phone number of alternate conservator)

No bond shall be required of either of them in any jurisdiction.

These requests, appointments, and designations are made after careful reflection, while I am of sound mind. Any party receiving a duly executed copy or facsimile of this document may rely upon it unless such party has received actual notice of my revocation of it.

Date \_\_\_\_\_, 20\_\_\_\_ L.S.

WITNESSING  
PROCEDURE

**CONNECTICUT HEALTH CARE INSTRUCTIONS - PAGE 6 OF 7**

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**WITNESSES' STATEMENTS**

PRINT YOUR NAME

This document was signed in our presence by \_\_\_\_\_

TWO WITNESSES  
SIGN BELOW AND  
PRINT THEIR  
NAMES AND  
ADDRESSES

\_\_\_\_\_, the author of this document,  
who appeared to be eighteen years of age or older, of sound mind and  
able to understand the nature and consequences of health care decisions  
at the time this document was signed. The author appeared to be under  
no improper influence. We have subscribed this document in the author's  
presence and at the author's request and in the presence of each other.

WITNESS # 1

Witness \_\_\_\_\_

Printed Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

WITNESS #2

Witness \_\_\_\_\_

Printed Name \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

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INSTRUCTIONS

WITNESS  
AFFIDAVIT FOR  
WITNESSES

OPTIONAL FORM TO  
BE COMPLETED BY  
A NOTARY PUBLIC

YOUR WITNESSES  
MUST SIGN AND  
PRINT THEIR  
NAMES

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**CONNECTICUT HEALTH CARE INSTRUCTIONS - PAGE 7 OF 7**

**WITNESS AFFIDAVITS**

STATE OF CONNECTICUT )  
 : ss. \_\_\_\_\_  
COUNTY OF \_\_\_\_\_ ) (Town/City)

We, the subscribing witnesses, being duly sworn, say that we witnessed the execution of these health care instructions, the appointments of a health care representative, the designation of a conservator for future incapacity and a document of anatomical gift by the author of this document; that the author subscribed, published and declared the same to be the author's instructions, appointments and designation in our presence; that we thereafter subscribed the document as witnesses in the author's presence, at the author's request, and in the presence of each other; that at the time of the execution of said document the author appeared to us to be eighteen years of age or older, of sound mind, able to understand the nature and consequences of said document, and under no improper influence, and we make this affidavit at the author's request this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_ .

Witness \_\_\_\_\_

Printed Name \_\_\_\_\_

Witness \_\_\_\_\_

Printed Name \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_.

\_\_\_\_\_  
Commissioner of the Superior Court Notary Public

My commission expires: \_\_\_\_\_

*Courtesy of Caring Connections  
1731 King St., Suite 100, Alexandria, VA 22314  
www.caringinfo.org, 800/658-8898*

## **You Have Filled Out Your Advance Directive, Now What?**

1. Your *Connecticut Advance Directive for Healthcare* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your proxy and alternate proxy, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.
3. Be sure to talk to your representative and alternate, doctor(s), clergy and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
5. Remember, you can always revoke your Connecticut document.
6. Be aware that your Connecticut document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR.  
These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**