

# **TENNESSEE**

## **Advance Directive**

### **Planning for Important Healthcare Decisions**

Courtesy of CaringInfo

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

CaringInfo, a program of the National Alliance for Care at Home (the Alliance), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- 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.

#### **BEFORE YOU BEGIN**

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

#### **ACTION STEPS**

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. 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.
4. Once the form is completed and signed, photocopy, scan, or take a photo of 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.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

## **INTRODUCTION TO YOUR TENNESSEE ADVANCE HEALTH CARE DIRECTIVE**

This packet contains a legal document, known as a **Tennessee Advance Directive**, that 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. This document is based on forms created by the Tennessee Department of Health.

**Page one** includes an **Appointment of Health Care Agent**. This lets you name someone, called an agent, to make decisions about your medical care — including decisions about life support — if you can no longer speak for yourself. An agent can speak for you any time you are unable to make your own medical decisions, not only at the end of life.

**Pages two and three** contain an **Individual Instruction** that lets you provide your wishes regarding medical care in the event that you can no longer speak for yourself. In addition to health care decisions, the individual instruction portion of the form also allows you to give instructions regarding your other advance planning concerns, such as your burial wishes. Finally, the individual instruction portion of the form allows you to make a declaration of your wishes regarding organ donation.

**You must fill out either page four or page five for the document to be effective.**

### **How do I make my Tennessee Advance Health Care Directive legal?**

You must sign your advance directive. Your signature must either be notarized or witnessed by two competent adults. Either option is available with this form.

If you have your signature witnessed, the witnesses cannot be the person you name as your agent. In addition, at least one of your witnesses must be a person 1) who is not related to you by blood, marriage, or adoption; and 2) who will not inherit any part of your estate.

### **Whom should I appoint as my agent?**

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

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

## **Should I add personal instructions to my advance directive?**

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

## **When does my agent's authority become effective?**

Your advance directive goes into effect when your designated physician determines that you are no longer able to understand the significant benefits, risks, and alternatives to proposed healthcare and to make and communicate a healthcare decision.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

## **Agent Limitations**

Your agent will be bound by the current laws of Tennessee as they regard pregnancy and termination of pregnancies.

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

You may revoke all or part of your advance directive, except for the designation of an agent, at any time you have capacity and in any manner that communicates an intent to revoke. This could include tearing, burning, or otherwise destroying the document or simply stating orally that you intend to revoke your advance directive.

You may revoke the designation of your agent only by a signed writing or by personally informing your supervising health care provider. If your spouse is your agent, a decree of annulment, divorce, dissolution of marriage, or legal separation automatically revokes his or her power, unless you specify otherwise in your advance directive.

You can also draft a new advance directive. An advance directive that conflicts with an earlier advance directive revokes the earlier directive to the extent of the conflict.

## **Mental Health Issues**

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (<https://nrc-pad.org/>) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

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

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (<https://www.hhs.gov/aging/state-resources/index.html>). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (<https://polst.org/form-patients/>). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

**TENNESSEE ADVANCE DIRECTIVE  
PAGE 1 OF 5**

**APPOINTMENT OF HEALTH CARE AGENT**

INSERT YOUR NAME

I, \_\_\_\_\_, give my agent named below permission to make health care decisions for me if I cannot make decisions for myself. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

**Agent:**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relation: \_\_\_\_\_

Address:

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**Alternate Agent:**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Relation: \_\_\_\_\_

Address:

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**Other Instructions or Limitations for my Agent:**

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ADD YOUR AGENT'S  
NAME, PHONE  
NUMBER, RELATION  
TO YOU, AND  
ADDRESS

ADD YOUR  
ALTERNATE  
AGENT'S NAME,  
PHONE NUMBER,  
RELATION TO YOU,  
AND ADDRESS

ADD ANY  
LIMITATIONS OR  
INSTRUCTIONS YOU  
HAVE FOR YOUR  
AGENT

**TENNESSEE ADVANCE DIRECTIVE  
PAGE 2 OF 5**

**INDIVIDUAL INSTRUCTION**

INSERT YOUR NAME

**QUALITY OF LIFE  
STATEMENT**

CHECK THE BOXES  
FOR CONDITIONS  
THAT YOU DO NOT  
CONSIDER AN  
ACCEPTABLE  
QUALITY OF LIFE

YOU CAN CHECK AS  
MANY OF THESE  
ITEMS AS YOU  
WANT, OR ADD  
ADDITIONAL  
CONDITIONS IN  
THE "OTHER  
INSTRUCTIONS" ON  
THE NEXT PAGE

**TREATMENT  
INSTRUCTIONS**

CHECK THE "YES"  
BOXES IF YOU  
WANT TO RECEIVE  
THE TREATMENT

CHECK THE "NO"  
BOXES IF YOU DO  
NOT WANT TO  
RECEIVE THE  
TREATMENT

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I, \_\_\_\_\_, hereby give these individual instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. I do not consider the following conditions to be an acceptable quality of life:

☐ **Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.

☐ **Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.

☐ **Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.

☐ **End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to a feeling of suffocation.

If my condition is irreversible – that is, it will not improve – I direct that medically appropriate treatment be provided as indicated below. **If I mark "No" below, I authorize the withholding or withdrawal of such care:**

☐ Yes ☐ No **CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.

☐ Yes ☐ No **Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.

☐ Yes ☐ No **Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the primary illness.

☐ Yes ☐ No **Artificially Provided Nourishment and Fluids:** Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

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### OTHER INSTRUCTIONS

**Other Instructions (Optional):**

ADD OTHER  
INSTRUCTIONS, IF  
ANY, REGARDING  
YOUR ADVANCE  
CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH  
ADDITIONAL PAGES  
IF NEEDED

CHECK THE APPROPRIATE BOXES

IF YOU WANT TO  
LIMIT YOUR  
ANATOMICAL GIFT,  
INDICATE THE  
LIMITATION HERE.

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Revised.

[illegible]

### **Organ Donation (Optional)**

☐ Upon my death, I DO NOT wish to make an anatomical gift

☐ Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue    ☐ My entire body    ☐ Only the following organs/tissues:

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**SIGNATURE**

Your signature must either be witnessed by two competent adults (Option A, below) or notarized (Option B, below). If witnessed, neither witness may be the person you appointed as your agent, and at least one of the witnesses must be someone who is not related to you by blood, marriage, or adoption or entitled to any part of your estate.

**OPTION A: SIGN WITH WITNESSES**

PRINT YOUR NAME

\_\_\_\_\_  
Principal's name (please print or type)

SIGN AND DATE  
YOUR ADVANCE  
DIRECTIVE

\_\_\_\_\_  
Signature of Principal Date  
(must be at least 18 or emancipated minor)

SIGNATURE OF  
WITNESS 1

I am a competent adult and have not been named as the Principal's agent. I witnessed the Principal's signature on this form.

\_\_\_\_\_  
Signature of witness number 1 Date

SIGNATURE OF  
WITNESS 2

I am a competent adult and have not been named as the Principal's agent. I am not related to the Principal by blood, marriage, or adoption and I am not entitled to any portion of the Principal's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the Principal's signature on this form.

\_\_\_\_\_  
Signature of witness number 2 Date



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**OPTION B: SIGN BEFORE A NOTARY**

PRINT YOUR NAME

\_\_\_\_\_  
Principal's name (please print or type)

SIGN AND DATE  
YOUR ADVANCE  
DIRECTIVE

\_\_\_\_\_  
Signature of Principal

\_\_\_\_\_  
Date

STATE OF TENNESSEE

COUNTY OF \_\_\_\_\_

HAVE YOUR  
SIGNATURE  
NOTARIZED

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is shown above as the "Principal." The Principal personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the Principal appears to be of sound mind and under no duress, fraud, or undue influence.

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

\_\_\_\_\_  
Signature of Notary Public