SASKATOON HEALTH REGION
Saskatoon, Saskatchewan

Patient/Resident Label

NAME: _____

HSN: _____

D.O.B.: _____

ADVANCE CARE DIRECTIVE
(Living Will)

Please Note:

This Advance Care Directive can only be made by a person 16 years[1] or older with capacity and is only in effect when that person lacks capacity to make health care decisions. A person with capacity may change their own directive at any time.

Name: _____

_____
Address City/Province

_____
Home Phone Work Phone Alternate Phone

To my family, my friends, my physicians, and all others to whom it may concern:

It is my intention that this directive be respected by my physician, my family, and my friends, if I am no longer capable of consenting to health care on my own behalf.

I am aware that this directive shall apply when I am no longer able to speak for myself. I would like to use the following information to help direct my care. Please read carefully, as these are three separate situations.

I understand that the health care team will meet with my appointed proxy/ies or substitute decision maker to discuss my prognosis, available interventions, and its benefit in my circumstances.

Please place a copy of this Advance Care Directive on my Health Record.

[1] The Health Care Directives and Substitute Health Care Decision Makers Act, Saskatchewan s.3

NAME: _____

HSN: _____

Proxies

A proxy must be 18 years[2] of age or older and have capacity to make decisions. The proxy has an obligation to act according to my known wishes. The proxy/ies listed below are authorized to consent to my health care when I am no longer able to understand health care information and communicate my own decisions.

Please appoint your proxy/ies below. You may appoint proxy/ies to act successively or jointly. Please circle successive proxies or joint proxies when appointing multiple proxies. Unless stated otherwise multiple proxies will be considered successive proxies.

1. Name: _____ Phone: _____

   _____

   Address City/Province

Successive Proxies or **Joint Proxies**

2. Name: _____ Phone: _____

   _____

   Address City/Province

3. Name: _____ Phone: _____

   _____

   Address City/Province

I understand that if I do not appoint a proxy, a substitute decision maker will be appointed to make health care decisions on my behalf when I lack capacity to make health care decisions. I have spoken to the following people about my wishes:

_____

Name Home Phone Work Phone

_____

Name Home Phone Work Phone

_____

Name Home Phone Work Phone

[2] The Health Care Directives and Substitute Health Care Decision Makers Act, Saskatchewan s.11(1)

ADVANCE CARE DIRECTIVE
(Living Will)

Situation A:

I have been diagnosed with an illness from which I am likely to recover. The following are my wishes...

Instructions:

The box below lists some interventions upon which you may wish to comment. Please indicate your wishes by placing your initials in the box for the interventions you would accept or not accept under Situation A.

Intervention	Yes, I would accept	No, I would not accept
I would be willing to accept all life supporting machines and treatments as needed while there is a chance of recovering.		
If your answer to the above question is "No, I would not accept", please initial below which interventions you would or would not accept.		
Cardiopulmonary Resuscitation (CPR) – this might include chest compressions, electric shocks and artificial breathing in an attempt to restart the heart.		
A machine to help me breathe (mechanical ventilation).		
A feeding tube inserted from the nose into the stomach.		
A feeding tube surgically inserted directly into the stomach.		
Other:		
Other:		

NAME: _____

HSN: _____

Situation B:

I suffer from an illness that may require many months or even years to recover. During that time, life support may be required to ensure the continuation of my life. The following are my wishes...

Instructions:

The box below lists some interventions upon which you may wish to comment. Please indicate your wishes by placing your initials in the box for the interventions you would accept or not accept under Situation B.

Intervention	Yes, I would accept	No, I would not accept
I would be willing to accept all life supporting machines and treatments as needed while there is a chance of recovering.		
If your answer to the above question is "No, I would not accept", please initial below which interventions you would or would not accept.		
Cardiopulmonary Resuscitation (CPR) – this might include chest compressions, electric shocks and artificial breathing in an attempt to restart the heart.		
A machine to help me breathe (mechanical ventilation).		
A feeding tube inserted from the nose into the stomach.		
A feeding tube surgically inserted directly into the stomach.		
Other:		
Other:		

Situation C:

If there is no expectation of my recovery, or death is inevitable and I would only be alive on life support. The following are my wishes...

Instructions:

The box below lists some interventions upon which you may wish to comment. Please indicate your wishes by placing your initials in the box for the interventions you would accept or not accept under Situation C.

Intervention	Yes, I would accept	No, I would not accept
Cardiopulmonary Resuscitation (CPR) – this might include chest compressions, electric shocks and artificial breathing in an attempt to restart the heart.		
A machine to help me breathe (mechanical ventilation).		
A feeding tube inserted from the nose into the stomach.		
A feeding tube surgically inserted directly into the stomach.		
Other:		
Other:		
Other:		
Other:		

NAME: _____

HSN: _____

Further wishes:_____

_____

_____

_____

_____

_____

Signed and declared:

If you are physically **able** to, sign your name and date below.

_____

Name Signature Date

If you are physically **unable** to sign, a person of your choice may complete this directive and sign on your behalf at your instruction. The signature of this person must be witnessed and the witness must sign below. A person appointed as a proxy or a proxy's spouse cannot sign as a witness or as the person signing on your behalf.

_____

Name Signature of the person who is signing on my behalf Date

_____

Name Signature of Witness Date

Please Note:

When making a directive, it is a good idea to make copies available to your proxy/ies or substitute decision maker, family members, your doctor, your Special Care Home care providers and any health care facility to which you are admitted. You may also place a copy on or in your refrigerator for ease of access in emergencies.

Please cut on the dotted line and place the card in your wallet. When printing from a PDF document please select actual size under the print option.

Medical Alert (Wallet Card)

TO MY FAMILY, MY PHYSICIAN & HOSPITAL

I have completed an Advance Care Directive. In case of accident or extreme sudden illness please follow my Directive as soon as available. It can be obtained by contacting the individuals listed on the back.

Health Records please discard this page and do not scan into patient record. Thank you

Name: _____

Phone Number: _____

My Proxy is:

Name: _____

Phone Number: _____

PLEASE

DO NOT

DOCUMENT

ON THIS PAGE

Health Records please discard this page and
do not scan into patient record. Thank you