Heartland Health Region

Health Care Directives

Completion of this form is optional

I have indicated on the reverse side of this page my Substitute Health Care Decision Maker (Health Care Proxy) in the event I have chosen to appoint one.
____ YES ____NO

Name: ____________________________
Address ____________________________
City ____________________________
Province _______ **Postal Code**_________
Provincial Health #________________________

- **This directive will apply in the event that I am no longer able to make or communicate decisions for my own health care.**
- **This directive will have no force or effect if revoked by me verbally or in writing.**

In this section I have indicated the treatment/procedures that are acceptable or not acceptable to me for my health care when I am no longer able to indicate my wishes for treatment.

When death is inevitable, I want to be kept comfortable and I accept and expect treatment or medication necessary to provide me with compassionate care.

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____

I, ____________________, voluntarily make this directive concerning my health care.

_________________________ _____________________
Client Signature **Date**

_________________________ _____________________
Witness **Date**

Please notify your physician / care providers of the existence of your Directive and give them either this original or a copy to be placed on your health record. If you change or revoke your Directive you MUST inform your physician / care providers and replace with a current document.

Appointment of Substitute Health Care Decision Maker

(also known as a Health Care Proxy Appointment)

Completion of this form is optional

The purpose of this Appointment is to designate the Substitute Health Care Decision Maker (Health Care Proxy)
for____
(Please Print Client's Name)

Provincial Health # ___________________________________

Substitute Health Care Decision-Maker(s) Appointment

I hereby appoint the following person(s) to be my Substitute Decision-Maker(s). This person or persons will have the authority to make health care decisions on my behalf **when I lack the ability or capacity to make them for myself**.

(Please print)

Substitute Health Care Decision Maker Name: ____

Address: ____

____

Phone #: ____
(or other contact information – i.e. cell phone, e-mail, etc.)

Substitute Health Care Decision Maker Name: ____

Address: ____

____

Phone # : ____
(or other contact information – i.e. cell phone, e-mail, etc.)

I have named more than one Substitute Health Care Decision Maker, I wish them to act: (*check your choice):*

☐ In the order which they were listed (i.e. individually and in succession)
☐ Together

Client's Signature: __________________________ **Date:** __________________

Witness: ___________________________________ **Date:** __________________

This is a legal document and will remain valid until changed or destroyed by the client making the above Substitute Health Care Decision Maker appointment. **It is illegal to sign or make a health care directive or appoint a proxy for another person** as per *The Health Care Directives and Substitute Health Care Decision Makers Act (1998, 2004).*