

Advance Directives

The Patient Self-Determination Act requires that we ask you whether or not you have an advance directive or would like to execute an advance directive when you are admitted to the hospital. Advance directive is a general term for written or oral statements that allow you to express your wishes about life-prolonging procedures at the end of life and the person you may choose to make healthcare decisions for you if you become unable to make these decisions for yourself.

Our intent in providing this information to you is for you to be able to think ahead about these important decisions. Our desire is to provide you with the best healthcare in accordance with your wishes. Please execute the advance directive if you choose, though you are not required to do so. If you would like assistance or if you have questions, please contact:

Baptist Hospital of Miami

Social Work . . . 786-596-6578

Pastoral Care . . . 786-596-6577

South Miami Hospital

Social Work . . . 786-662-8106

Pastoral Care . . . 786-662-5392

Doctors Hospital

Social Work . . . 305-663-5923

Pastoral Care . . . 305-668-2183

Homestead Hospital

Social Work . . . 786-243-8508

Pastoral Care . . . 786-243-8551

Mariners Hospital

Social Work . . . 305-434-1625

Pastoral Care . . . 305-434-1585



**Baptist Health
South Florida**

BAPTIST HOSPITAL OF MIAMI • SOUTH MIAMI HOSPITAL • DOCTORS HOSPITAL
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BAPTIST OUTPATIENT SERVICES • BAPTIST CARDIAC & VASCULAR INSTITUTE

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Advance Directives

ADVANCE DIRECTIVES

You may fill out any, all or none of the three sections below.

Designation of Healthcare Surrogate

Fill this out if you wish to choose someone to make all your healthcare decisions if you become too sick to tell others what you want. This person is called a healthcare surrogate.

In the event that it has been determined that I am unable to express my wishes regarding my healthcare, including the withholding, withdrawal or continuation of life-prolonging procedures, I, _____, born ____/____/____, wish to designate as my SURROGATE to carry out the provisions of this declaration:

Name: _____ Relationship: _____
Phone: _____ Address: _____

If my surrogate is unwilling or unable to perform his/her duties, I wish to designate as my ALTERNATE SURROGATE:

Name: _____ Relationship: _____
Phone: _____ Address: _____

I have I have not formulated a Living Will before this admission.

Additional instructions (optional): _____

Signature: Sign the form. Have two witnesses sign the form. Tell others about your decision and give copies to your doctor and family. Bring the form to the hospital at the time of admission.

I understand the importance of this declaration, and I am emotionally and mentally competent to make this declaration. These directives express my legal right to preserve my right to privacy and self-determination. Therefore, I expect my family, physician and all those concerned with my care to regard themselves as legally and morally bound to act according to my wishes.

_____ Patient's Signature	_____ Date	_____ Witness to Signature	_____ Witness to Signature
ONLY ONE OF THE WITNESSES MAY BE A SPOUSE OR BLOOD RELATIVE. A SURROGATE CANNOT BE A WITNESS.		_____ Print Name/Relationship	_____ Print Name/Relationship

Organ Donation

Fill this out if you wish to donate your organs at death.

Upon my death, I, _____, born ____/____/____, wish to donate any or certain parts of my body for the purpose of transplantation.

Specifically, I wish to donate the following parts of my body: _____

_____ Patient's Signature	_____ Date	_____ Witness to Signature	_____ Witness to Signature
ONLY ONE OF THE WITNESSES MAY BE A SPOUSE OR BLOOD RELATIVE. A SURROGATE CANNOT BE A WITNESS.		_____ Print Name/Relationship	_____ Print Name/Relationship

Living Will

Fill this out if you choose, or you may provide a document of your own.

Patient Name: _____
Last name First name Middle initial

Declaration made this _____ day of _____ in the year of _____ I, _____, born ____/____/____, willfully and voluntarily make known my desire that my dying shall not be prolonged under the circumstances set forth below:

It is my wish that my life not be artificially prolonged if I am unable to communicate healthcare decisions and: I have a terminal condition; or I have an end-stage condition; or I am in a persistent vegetative state. If my doctor determines that there is no reasonable probability of my recovery, and another consulting physician confirms this, then I request that life-prolonging procedures be withheld or withdrawn. Medications and medical procedures should be provided only if they give me comfort or ease my pain.

Other personal instructions: _____

My family and physicians should honor this declaration as the final expression of my right to refuse medical or surgical treatment, even if the consequence is my death.

I have I have not designated a Healthcare Surrogate before this admission.

Signature: Sign the form. Have two witnesses sign the form. Tell others about your decision and give copies to your doctor and family. Bring the form to the hospital at the time of admission.

I understand the importance of this declaration, and I am emotionally and mentally competent to make this declaration. These directives express my legal right to preserve my right to privacy and self-determination. Therefore, I expect my family, physician and all those concerned with my care to regard themselves as legally and morally bound to act according to my wishes.

_____ Signature	_____ Date	_____ Witness to Signature	_____ Witness to Signature
ONLY ONE OF THE WITNESSES MAY BE A SPOUSE OR BLOOD RELATIVE. A SURROGATE CANNOT BE A WITNESS.		_____ Print Name/Relationship	_____ Print Name/Relationship

