YUKON

Directive

A. NOTES

A1 **“Directive” = Advance Directive**

A2 **To complete a Directive, you (the “Maker”) must:**

- Be **16** years of age or older
- Be mentally capable

A3 **“Proxy” = Substitute Decision-Maker**

A4 **A Proxy must:**

- Be **19** years of age or older
- Be mentally capable
- Agree to be your Proxy

A5 **You must sign your Directive in the presence of TWO witnesses. The Proxy/Proxies may sign separately.**

A6 **If you cannot complete and sign this Directive yourself, someone else can sign it for you. This must be done in your presence and the presence of TWO witnesses. This person cannot be your Proxy, Proxy’s spouse, or a witness.**

A7 **The witnesses must:**

- Be **19** years of age or older
- **NOT** be the same person you chose as your Proxy, nor their spouse
- Sign the Directive in your presence, and each other’s presence

A8 **If you feel you have special circumstances that the Dying With Dignity Canada forms do not address, we suggest that you consult with a lawyer.**

B. PERSONAL INFORMATION

B1 **I, ______________________________ revoke (cancel) any previous Directives made by me.**
(NAME)

B2 **Legal first name:** ______________________________

B3 **Legal last name:** ______________________________

B4 **Preferred name** (If different from legal name)**:** ______________________________

B5 **Pronouns** (Optional)**:** ______________________________

B6 **Date of birth:** ______________________________

B7 **Address:** ______________________________

B8 **Phone:** ______________________________

B9 **Email:** ______________________________

B10 **Health number:** ______________________________

C. APPOINTING A PROXY

(RECOMMENDED, BUT OPTIONAL)

C1 I appoint (choose) the following people to make health care decisions for me if I am no longer mentally capable of making health care decisions for myself:

PROXY #1

C2 **First name:** ______________________________

C3 **Last name:** ______________________________

C4 **Relationship to me:** ______________________________

C5 **Address:** ______________________________

C6 **Phone:** ______________________________

C7 **Email:** ______________________________

PROXY #2 (OPTIONAL)

C8 **First name:** ______________________________

C9 **Last name:** ______________________________

C10 **Relationship to me:** ______________________________

C11 **Address:** ______________________________

C12 **Phone:** ______________________________

C13 **Email:** ______________________________

NOTE: Only complete the next section if you choose more than one Proxy.

C14 **I want my Proxies to act:**

__________ **Alternately** (Any one of them can make a decision)
(INITIAL)

__________ **Successively** (The second Proxy will only make decisions if the first is unavailable)
(INITIAL)

C15 I authorize my Proxy/Proxies to make medical decisions on my behalf when I lack the capacity to do so for myself.

__________ **With no restrictions**
(INITIAL)

__________ **With the following restrictions** (please describe)
(INITIAL)

____

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D. HEALTH CARE DIRECTIONS

(PLEASE READ EACH LINE CAREFULLY)

D1 ______________ **If I am sedated and unable to communicate, I would like the sedation lifted so that I can decide for myself to accept or refuse a particular therapy.**
(INITIAL)

D2 **Initial only ONE of the following two options. If you choose Option 1, skip to page 6.**

______________ **Option 1:** I direct that my life be prolonged, and that I be provided **all life-sustaining treatments** that apply to my medical condition.
(INITIAL)

OR

______________ **Option 2:** I direct that I **only receive care that will keep me comfortable and pain free**, and that my life is not prolonged (initial the options that apply below).
(INITIAL)

______________ **In any circumstance**
(INITIAL)

______________ **If I experience a serious life-threatening illness that cannot be reversed**
(INITIAL)

______________ **If I experience permanent, chronic, and debilitating suffering**
(INITIAL)

______________ **If I have advanced dementia** (please describe what this would look like for you)
(INITIAL)

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____

______________ **OTHER** (please explain)
(INITIAL)

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D3 **I specifically REFUSE (say no to) the following (initial where you refuse):**

________ (INITIAL) **Electrical, mechanical, or other artificial stimulation of my heart** (such as CPR)

________ (INITIAL) **Respirator or ventilator**

________ (INITIAL) **Artificial feeding such as through a stomach tube, or an intravenous line** (IV)

________ (INITIAL) **Being spoon fed, if I am no longer able to feed myself**

________ (INITIAL) **Artificial hydration** (fluids) **by intravenous line**

________ (INITIAL) **Antibiotics**

________ (INITIAL) **Transfer to an intensive care unit or similar facility**

D4 **I would prefer to be cared for (select one):**

________ (INITIAL) **At home**

________ (INITIAL) **In hospice**

________ (INITIAL) **In hospital**

D5 ________ (INITIAL) **If my health care provider will not follow this Directive, I ask that my care be transferred to another health care provider who will respect my legal rights.**

D6 ________ (INITIAL) **If I should be a patient in a health care facility which will not follow this Directive, I ask that I be transferred to another facility.**

ADDITIONAL DIRECTIONS:

____

____

____

____

____

____

MEDICAL ASSISTANCE IN DYING AND ADVANCE REQUESTS

D7 I understand that the current laws of Canada do not allow me to request medical assistance in dying (MAID) in advance. I understand that my Proxy cannot consent to MAID on my behalf. If the law changes, here are my directions regarding MAID. I wish for my Proxy and health care providers to act on my directions below.

E. SIGNATURES

MY SIGNATURE (THE “MAKER”)

E1 **First name:** ____________________

E2 **Last name:** ____________________

E3 **Signature:** ____________________

E4 **Date:** ____________________

OR

SIGNATURE ON MY BEHALF (IN THE PRESENCE OF THE WITNESS BELOW)

E5 **First name:** ____________________

E6 **Last name:** ____________________

E7 **Relationship to the “Maker”:** ____________________

E8 **Signature:** ____________________

E9 **Address:** ____________________

E10 **Phone:** ____________________

E11 **Email:** ____________________

E12 **Date:** ____________________

PROXY #1

I agree to be the Proxy for the person who created this Directive. I understand the responsibilities that come with this role under the ***Care Consent Act***.

E13 **First name:** ______________________________

E14 **Last name:** ______________________________

E15 **Signature:** ______________________________

E16 **Date:** ______________________________

PROXY #2 (OPTIONAL)

I agree to be the Proxy for the person who created this Directive. I understand the responsibilities that come with this role under the ***Care Consent Act***.

E17 **First name:** ______________________________

E18 **Last name:** ______________________________

E19 **Signature:** ______________________________

E20 **Date:** ______________________________

WITNESS #1

I certify that I witnessed the signing of this Directive. I certify that my signature is made in the presence of the Maker and Witness #2. I declare that I am not the Proxy nor the spouse of the Proxy.

E21 **First name:** ____________________

E22 **Last name:** ____________________

E23 **Signature:** ____________________

E24 **Address:** ____________________

E25 **Phone:** ____________________

E26 **Email:** ____________________

E27 **Date:** ____________________

WITNESS #2

I certify that I witnessed the signing of this Directive. I certify that my signature is made in the presence of the Maker and Witness #1. I declare that I am not the Proxy nor the spouse of the Proxy.

E28 **First name:** ____________________

E29 **Last name:** ____________________

E30 **Signature:** ____________________

E31 **Address:** ____________________

E32 **Phone:** ____________________

E33 **Email:** ____________________

E34 **Date:** ____________________

F. DISTRIBUTION

I have shared this Directive with the following people. This is a reminder to me to keep these people informed of any changes. I am aware that outdated copies of my Directive may create confusion.

F1 **Name:** ______________________________

F2 **Name:** ______________________________

F3 **Name:** ______________________________

F4 **Name:** ______________________________

F5 **Name:** ______________________________

F6 **Name:** ______________________________

G. REVIEW

G1 You should review your Directive:

- At least every three years
- When your health situation changes
- When your Proxy/Proxies change(s)

__________ **Date of last review:** ______________________________
(INITIAL)

__________ **Date of last review:** ______________________________
(INITIAL)

__________ **Date of last review:** ______________________________
(INITIAL)

__________ **Date of last review:** ______________________________
(INITIAL)

H. NEXT STEPS

H1 **After completing your Directive, re-read it to ensure your preferences are clear.** Then, review it with your Proxy/Proxies. If a health care provider does not know you well, they may need a copy of the Directive to understand your wishes for care.

H2 Keep a copy of your Directive in an easy-to-find place in an emergency. Leave a note in a prominent place, such as on your fridge with a magnet. This will let emergency personnel know where to look and who to call in a crisis. You can also print a wallet card and fridge note from the Dying With Dignity Canada website at ***dyingwithdignity.ca/advance-care-planning***.

H3 **Do not store your Directive in any locked box, drawer or safe.**

H4 Discuss your completed Directive with your health care provider. Give them a copy to put in your medical file. However, do not assume that doing so will result in your Directive being available in an emergency. You or your Proxy/Proxies must ensure health care providers are provided with a copy of your Directive. That is why you should appoint a Proxy.

H5 If there are no changes to be made, sign the Directive again with the new date.

H6 Your medical condition may change. Or you may reconsider some of the directions you wrote down. Download a new Directive at ***dyingwithdignity.ca/advance-care-planning*** or call Dying With Dignity Canada (DWDC) toll free at **1-800-495-6156** to receive a copy in the mail. Tell everyone involved in your care that you have updated your Directive.