Advanced Healthcare Directive / Document of Advanced Wills / Living wills

First Name ..... Last name.....

ID Card/Passport number ....

Home address. ....

Postcode.. ..... City ..... Telephone ....

I have sufficient capacity to make a decision freely, and with the appropriate information that has allowed me to deeply consider and reflect on this matter.

1. **I State:**

   In accordance with Law 21/2000 of the Parliament of Catalonia and Basic Law 41/2002 of the Spanish State, I hereby sign this Document of Advanced Wills. **This is so that when** I find myself in a situation in which I become unable to make my own decisions or express my own will, the values and preferences **that the instructions** I set out are based upon shall be known. I want them to be respected regarding my health care.

2. **LIFE VALUES:** For my life project, the **quality of life** is a very important aspect and I relate this quality of life to the following assumptions:

   ☐ I have the ability to communicate and relate consciously with other people.

   ☐ I do not suffer physical or mental pain.

   ☐ I have functional capacity which allows me to be autonomous in daily life.

   ☐ I don't want my life to be artificially prolonged when the clinical situation is irreversible.

   ASSUMPTIONS AND SITUATIONS: I want the aforementioned vital values to be respected in the following situations:

   ☐ I have a severe and irreversible brain damage, from any cause or even by accident

   ☐ I suffer a degenerative disease in the disabling phase.

   ☐ I have reached an advanced old age with significant deterioration in my general condition.

   ☐ I suffer a disease with a fatal prognosis.

   ☐ I am in a situation in which there are no expectations of recovery without consequences that prevent a dignified life as I understand it and I expressed in the previous section.

Select the one option from the three below that you would like your instructions to be followed from.

☐ **Moderate dementia**, which prevents me from living alone and/or carrying out activities such as: going out unaccompanied, cooking, shopping, ...

☐ **Moderately severe dementia**, which makes it impossible to fend for myself in activities such as: dressing, showering, eating alone, going to the toilet, reading, writing,...

☐ **Severe dementia**, which prevents me from: communicating or recognizing people close to me emotionally and/or keeps me immobilized in a chair or in bed, ...

3. INSTRUCTIONS ON HEALTH ACTIONS:

In the situations previously expressed I want the adequacy of the diagnostic and therapeutic efforts to be carried out:

☐ Not initiating cardiopulmonary resuscitation

☐ Not initiating or withdrawing treatments that would prolong my life by artificial means with life support techniques or futile treatments of any kind.

☐ Administering the necessary drugs to avoid possible physical and/or mental suffering, reaching, if necessary, deep and continuous palliative sedation.

☐ If my dementia makes me unable to feed and hydrate myself, I do not want to be fed or hydrated by any procedure.

☐ I only accept mechanical or pharmacological restraint when it is to avoid harm to myself or to third parties, and always with a medical prescription.

☐ Faced with a complication of my condition, whenever possible, I want to be taken care of in the place where I reside.

☐ Some pathologies are characterized by a lack of illness awareness. If, at a time of executing my will as expressed in this document, I express an opinion that differs from its content, I demand that my will as stated herein prevail.

☐ Subject to the fulfillment of the requirements set out in the current legislation, I hereby request medical assistance in dying via euthanasia. I wish for this document to serve as a formal application for such assistance.

☐ I hereby donate my organs and tissues.

4. ADDITIONAL STATEMENTS:

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5. I REQUEST:

Health professionals who are not in a position to attend to my wishes should refer me to another care team that can.

APPOINTMENT AS REPRESENTATIVE (optional),

In the event that I am unable to express my wishes, and in accordance with current legislation, I appoint the following individuals as my representatives for the interpretation and application of this document, in accordance with the healthcare team that will care for me:

Signature of the representative:

First Name ..... Last name.....

ID Card/Passport number ....

Home address. ....

Postcode.. ..... City ..... Telephone ....

Alternate representative:

First Name ..... Last name.....

ID Card/Passport number ....

Home address. ....

Postcode.. ..... City ..... Telephone ....

Signature of the person making this Advanced Healthcare Directive

City.....

Date.....

Signature: