SAMPLE HEALTH CARE PROXY

Adapted by PsychRights to provide for the rejection of psychotropic medication from

The Incapacitated Client: Personal Decision Making

by Robert H. Weber, Esq.

http://weberandbaum.com/pages/mcle.html

MASSACHUSETTS HEALTH CARE PROXY

TO MY FAMILY, DOCTORS, AND
ALL THOSE CONCERNED WITH MY CARE:

1. Appointment

I, _____ (the principal), residing at _____ _____, Massachusetts _____, being a competent adult at least eighteen years of age or older, of sound mind and under no constraint or undue influence, hereby appoint the following person to be my HEALTH CARE AGENT under the terms of this document:

Name: _____
Address: _____ , Massachusetts _____
Telephone: _____

In so doing, I intend to create a Health Care Proxy according to Chapter 201D of the General Laws of Massachusetts. In making this appointment, I am giving my Health Care Agent the authority to make any and all health care decisions on my behalf, including decisions about life-sustaining treatment, subject to any limitations I state in this document, in the event that I should at some future time be-come incapable of making health care decisions for myself.

2. Alternate Appointment

I hereby appoint the following person to serve as my Health Care Agent in the event that my original Health Care Agent is not available, willing or competent to serve and is not expected to become available, willing or competent to make a timely decision given my medical circumstances, or in the event that my original Health Care Agent is disqualified from acting on my behalf.

Name: _____
Address: _____ _____
Telephone: _____

3. Powers Given to Health Care Agent

A. I give my Health Care Agent full authority to make any and all health care decision for me including decisions about life-sustaining treatment, subject only to the limitations I state below.

B. My Health Care Agent shall have authority to act on my behalf only if, when and for so long as a determination has been made that I lack the capacity to make or to communicate health care decision for myself. This determination shall be made in writing by my attending physician according to accepted standards of medical judgment and the requirements of Chapter 201D of the General Laws of Massachusetts.

C. The Authority of my Health Care Agent shall cease if my attending physician determines that I have regained capacity. The authority of my Health Care Agent shall recommence if I subsequently lose capacity and consent for treatment is required.

D. I shall be notified of any determination that I lack capacity to make or communicate health care decisions where there is any indication that I am able to comprehend this notice.

E. My Health Care Agent shall make health care decisions for me only after consultation with my health care providers and after full consideration of accept-able medical alternatives regarding diagnosis, prognosis, treatments and their side effects.

F. My Health Care Agent shall make health care decisions for me only in accordance with my Health Care Agent's assessment of my wishes, including my religious and moral beliefs, or, if my wishes are unknown, in accordance with my Health Care Agent's assessment of my best interests.

G. My Health Care Agent shall have the right to receive any and all medical information necessary to make informed decisions regarding my health care, including any and all confidential medical information that I would be entitled to receive.

H. The decisions made by my Health Care Agent on my behalf shall have the same priority as my decisions would have if I were competent over decisions by any other person, including a person acting pursuant to a durable power of attorney, except for any limitation I state below or a specific Court Order overriding this Health Care Proxy.

I. If I object to a health care decision made by my Health Care Agent, my decision shall prevail unless it is determined by Court Order that I lack capacity to make health care decisions.

J. Nothing in this proxy shall preclude any medical procedure deemed necessary by my attending physician to provide comfort care or pain alleviation including but not limited to treatment with sedatives and painkilling drugs, non-artificial oral feeding, suction, and hygienic care.

K. **(OPTIONAL)** I understand that by signing this document I am giving my health care agent the authority to exercise his/her best judgment regarding all health care decisions including decisions about life-sustaining treatment. Regarding decisions about life-sustaining treatment, as authorized under Section 5 of M.G.L. c. 201D, it is my desire that my agent may be guided by the following statement of my beliefs. I believe that death is a natural part of life. Dying should not be un-necessarily prolonged, to my own detriment and indignity, and to the agony of my family. While I believe in the sanctity of life, I feel that circumstances may exist in which the effort to sustain my life may itself degrade or demean the humanity without which I feel my life has no meaning. I believe also that I have the right to refuse medical treatment, whether or not I am mentally competent to do so, and that my family, guardian, attorney and physicians should undertake to act under this statement without guilt or feeling of responsibility on their part, since their actions are in furtherance of my wishes. Therefore, if I should become unable to participate meaningfully in decisions concerning my medical care and treatment, under the circumstances de-scribed below, or under similar circum-stances, it is my desire that my wishes as described be

carried out, as expeditiously as possible. This statement is made after careful consideration and reflection, and with full awareness of the pain, indignity, and discomfort which may itself accompany the withholding or withdrawal of care and sustenance, but with also the fullest faith that the judgment of my family and physicians in making any decision will comport with my wishes. It is therefore my intention that these directions be honored by my family and physicians as a final reflection of my le-gal right to refuse medical treatment under the conditions specified, and I accept the consequences of this refusal.

1. If I come to suffer an injury, disease or illness considered in-cur-able and terminal by my physicians, I direct my physicians and all medical personnel to withhold or withdraw all life-sustaining procedures which would serve only to prolong the dying process artificially, whether considered active or passive, ordinary or extraordinary, including, without limitation, the withholding of food and water.

2. If I suffer serious and irreversible brain damage as a result of any illness or injury to the extent that I have lost cognitive function with no significant likelihood of regaining it, whether or not I am terminally ill, I direct my physicians and all medical personnel to withhold or withdraw all life-sustaining procedures which would serve only to prolong the dying process artificially, whether considered active or passive, ordinary or extraordinary, including without limitation the withholding of food and water.

L. I specifically limit my Health Care Agent's authority as follows:

_____

_____

_____

_____

_____

_____

(OPTIONAL MENTAL HEALTH PROVISION DECLINING PSYCHIATRIC MEDICATIONS)
Example

1. I acknowledge that I received medication after being diagnosed with mental illness in the past. I have not found these medications helpful, they have caused me discomfort and pose health risks that are unacceptable to me. I have expressed my feelings about these medications to my health care agent and I have faith that he or she will not consent to the administration of any psychotropic medications.

2. Notwithstanding the foregoing, my agent may consent to the following medication or treatments under the following circumstances:

_____

_____

_____

_____

_____

_____

3. Instead of psychotropic medication, it is my wish that I be treated in the following manner:

_____

_____

_____

_____

_____

_____

My agent may not consent to the administration of any other treatment for mental illness.

4. My agent may not consent to the administration of electroshock, also known as electroconvulsive therapy.

4. Revocation

This Health Care Proxy shall be revoked upon any one of the following events:

A. my execution of a subsequent Health Care Proxy;

B. my divorce or legal separation from my spouse where my spouse is named as my Health Care Agent;

C. my notification to my Health Care Agent or a health care provider orally or in writing or by any other act evidencing a specific intent to revoke the Health Care Proxy.

5. Signature of Principal

I hereby sign my name to this Health Care Proxy in the presence of two witnesses.

Signature: _____
Date:

Complete here if the principal is physically incapable of signing:

I hereby sign the name of the principal at the principal's direction and in the presence of the principal and two witnesses.

Name of Principal: _____
Name of Signatory: _____
Date: _____
Address of Signatory: _____

6. Witnesses

WITNESS ONE: I, the undersigned, have witnessed the signing of this document by the principal or at the direction of the principal and state that the principal appears to be at least eighteen years of age, of sound mind and under no constraint or undue influence. I have not been named as Health Care Agent or alternate Health Care Agent in this document.

Signature: _____

Name (print): _____
Address: _____
_____
Date:

WITNESS TWO: I, the undersigned, have witnessed the signing of this document by the principal or at the direction of the principal and state the principal appears to be at least eighteen years of age, of sound mind and under no constraint or undue influence. I have not been named as Health Care Agent or alternate Health Care Agent in this document.

Signature: _____

Name (print): _____
Address: _____
_____
Date:

7. Statement of Health Care Agent and Alternate (Optional)

Health Care Agent:

I have been named by the principal as the principal's Health Care Agent in this document. *(Please check one)*

___ I am **not** an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other facility defined in section 70E of chapter 111 of the General Laws of Massachusetts where the principal is presently a patient or resident or has applied for admission.

___ I am an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other facility defined in section 70E of chapter 111 of the General Laws of Massachusetts where the principal is presently a patient or resident or has applied for admission, and I am also related to the principal by blood, marriage, or adoption.

I have read this document carefully and accept the appointment.

_____
Signature of Health Care Agent

Alternate Health Care Agent

I have been named by the principal as the principal's alternate Health Care Agent in this document.

___ I am **not** an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other facility defined in section 70E of chapter 111 of the General Laws of Massachusetts where the principal is presently a patient or resident or has applied for admission.

___ I am an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other facility defined in section 70E of chapter 111 of the General Laws of Massachusetts where the principal is presently a patient or resident or has applied for admission, and I am also related to the principal by blood, marriage, or adoption.

I have read this document carefully and accept the appointment.

_____
Signature of Alternate Health Care Agent