

A Guide to making an
**Advance
Health Care
Directive**



A guide to making an advance health care directive
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Authors

Tamayo Velázquez, MI

Simón Lorda, P

Méndez Martínez, C

García León, FJ

Design, layout and illustration

Laura Mudarra Rubio

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Index

GENERAL INFORMATION ABOUT ADVANCE HEALTH CARE DIRECTIVES.....	1
- What does this guide provide?.....	1
- What is an Advance Health Care Directive?.....	1
- Who can make an Advance Health Care Directive?.....	1
- What can I NOT include in my Advance Health Care Directive?.....	2
- How can I register my Advance Health Care Directive?.....	2
- Can I register my Advance Health Care Directive on the Internet?.....	4
- How will my Advance Health Care Directive be applied?.....	5
- Can I change my Advance Health Care Directive?.....	5
INFORMATION AND RECOMMENDATIONS ON HOW TO COMPLETE THE ANDALUSIAN ADVANCE HEALTH CARE DIRECTIVE DOCUMENT.....	6
- Information and suggestions on annex I.....	8
- Annex I: Registration in the Andalusian Registry of Advance Health Care Directives.....	9
- Information and suggestions on annex II.....	12
- Annex II: Advance Health Care Directive.....	13
- Information and suggestions on annex III.....	24
- Annex III: Acceptance of the person who will act as your Representative.....	25
- Information and suggestions on annex IV.....	26
- Annex IV: Acceptance of the person who will act as the Substitute of your Representative.....	27
GLOSSARY OF TERMS USED.....	29
- Living will.....	29
- Previous instructions.....	29
- Blood transfusion.....	29
- Nutrition and hydration.....	30
- Techniques of renal dialysis.....	32
- Artificial respirator.....	33
- Cardiopulmonary resuscitation.....	34
- Palliative sedation.....	34
- Impaired capacity of consent.....	34
- Life values.....	35
- Life support system.....	35
- Terminal situation.....	35
- Palliative care.....	35
- Refractory symptom.....	35
- Death Agony.....	36
- Permanent vegetative state.....	36
- Brain death.....	36
MORE INFORMATION ON ADVANCE HEALTH CARE DIRECTIVES.....	37
NOTES.....	39
APPENDIX 1. Official Advance Health Care Directive form in Andalusia.....	41

General Information about Advance Health Care Directives

What does this guide provide?

This guide **helps** people **residing** in Andalucía to fill in their **Advance Health Care Directives**, also known as a **Living Will**.

This document allows you to make known in advance and in writing your **wishes and preferences** about the health care that you wish to receive when you are unable to communicate because of illness.

This guide gives **simple and rapid** information about how to fill in the document and how to express your wishes.

It also contains additional information on Advance Health Care Directives and information on the **Andalusian Registry of Advance Health Care Directives**.

What is an Advance Health Care Directive?

An Advance Health Care Directive is a written document that contains our wishes and preferences about the **health care and treatment** that we would like to receive when we are unable to express our wishes personally.

It also allows us to choose a person we trust as our **Representative** or **Health Care Proxy** for making decisions on our behalf if we are in such a situation. A second **Representative** can also be appointed as a Substitute if, for some reason, the first one is unable to make these decisions.

Who can make an Advance Health Care Directive?

- Anyone over the **age of 18**.
- **Legally emancipated minors**.
- People declared **legally incapacitated**, providing there is no impediment in the legal sentence itself, and who, when deciding to make one, are capable of formalizing their declaration.

What can I NOT include in my Advance Health Care Directive?

Everyone has the **right to freely express his or her wishes**, whatever they may be, however you should be aware that health care professionals **shall not carry out instructions if**:

- They are **against the law**
e.g. "I wish to have euthanasia."
- They are **not clinically indicated**
e.g. "I want to receive all types of treatment available to keep me alive, including those that have not yet been proven useful or those that are experimental."

Health professionals should **respect your health care preferences** about withdrawing or not starting treatments. However, although you may request certain treatments in your directive you should be aware that certain treatments will only begin when medical professionals consider them to be **clinically indicated**.

How can I register my Advance Health Care Directive?

- 1** Together with your **Representative or Substitute**, speak to a health care professional that **you trust** about your health care preferences. Andalusian health professionals are obliged to give you information about Advance Health Care Directives.
- 2** If you so wish, you can **ask a health professional to help you in the process**. While this guide contains explanations regarding some of the most frequently used medical terms, a health professional can give you more detailed information and help you feel surer about what you want to be included in your Directive.
- 3** **Fill in the form** of Advance Health Care Directive (Annexes I, II, III, IV).

4 Request an appointment to register your document in the registration office nearest to your home:

- By Calling **Salud Responde: 902 50 50 60**



- By **internet** through the **Portal de Salud de la Junta de Andalucía**



<https://www.juntadeandalucia.es/salud/rv2/inicioCiudadania.action>

5 When you go to that appointment, be sure that you have all the **documentation** that you need:

- ✓ Personal identification (**DNI/NIE/Pasaporte**)
- ✓ **Completed Advance Health Care Directive form**
- ✓ If the **Representatives** you have appointed do not want their personal data to appear on identification verification systems, you should take along an **attested photocopy of their personal identification documents**, one for each of them.

Remember

The document of Advance Health Care Directives is **not a legal document** until it has been registered in the **Andalusian Registry of Advance Health Care Directives**.

Once your Advance Health Care Directive is registered, **access to it will be incorporated into your medical history**. This means that health professionals can consult it if necessary and guarantees that your wishes and preferences are respected.

It is important:

- That you **speak** to the **doctors and nurses** that normally treat you about the contents of your Advance Health Care Directive.
- That you **discuss** your wishes with your **nearest and dearest/family/friends**

In this way, everyone will be aware of your **wishes and preferences** and it will be easier to **respect** them when the time comes.

If your health does not permit you to complete the registration process, a staff member from the Registration Office will **visit your house or Health Centre** to assist you in making out your Declaration. To arrange for this, you should mention that fact when making your appointment through Salud Responde.

Can I register my Advance Health Care Directive on the Internet?

Many steps can be completed previously on-line.

<https://www.juntadeandalucia.es/salud/rv2/inicioCiudadania.action>

To do this you need to include your **personal details** (DNI/NIE/Passport and date of birth) in the application, or use **digital identity certificate**.

However, the **last step** requires a **personal appointment** with the Registry to finalise the process.

When applying on-line you can **complete the form and request an appointment at the Registry Office**. You can **only complete the documents, copy and print them out once**. However, if you have digital certification you can access and change the document as many times as you want before your appointment.

You **need** to have digital certification to access your Advance Health Care Directive once it has been registered. This will also enable you to see who else has accessed it.

Your Representatives can sign their acceptance (Annexes III and IV) using their own digital certification.

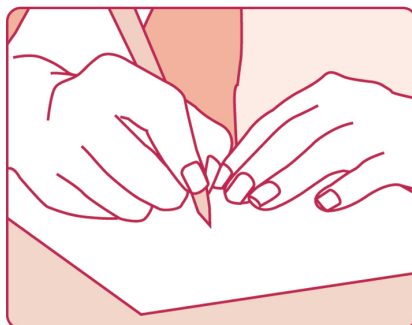
Remember: the documents you complete on-line will only become valid after you conclude your personal appointment at the Registry Office. Completing them previously only speeds up the registration process.

How will my Advance Health Care Directive be applied?

As long as you have **sufficient capacity to communicate your preferences**, healthcare professionals will take into account what you decide **at each moment**, not what is written in your Advance Health Care Directive. Your written Advance Health Care Directive will only be implemented in those situations in which you are unable to make decisions regarding your own health care or treatments, for example, if you are unconscious, in a coma or just incapable of deciding.

How will my Advance Health Care Directive be applied?

Yes. Your Advance Health Care Directive can be **rewritten, modified or cancelled** at any time. To do this you just have to follow the same steps you followed when registering the Declaration: call "Salud Responde" to obtain an appointment in the Registry or make one online.



Information and recommendations on how to complete the Andalusian Advance

To register an Andalusian Advance Health Care Directive, several documents have to be **completed**. These documents can be found in the following **annexes**:

- **Annex I: Registration in the Andalusian Registry of Advance Health Care Directives**

- This document is simply an “**administrative procedure**” through which you are requesting that your Directive be registered.

- **Annex II: Advance Health Care Directive**

- This is the document in which you express your **wishes and preferences**, thus making it the most important annex.
- The Directive consists of 6 parts.
- You do not have to fill them all in, you may leave some of them blank.

First: Reflects the **values** you want respected regarding health decisions that will affect you personally.

Second: Establishes the **clinical situations** in which you want this document to be applied.

Third: Identifies the **health actions** that you want or don't want to be carried out.

Fourth: Specifies your preferences about **organ and tissue donations**.

Fifth: Details other **considerations and preferences** that you want to establish.

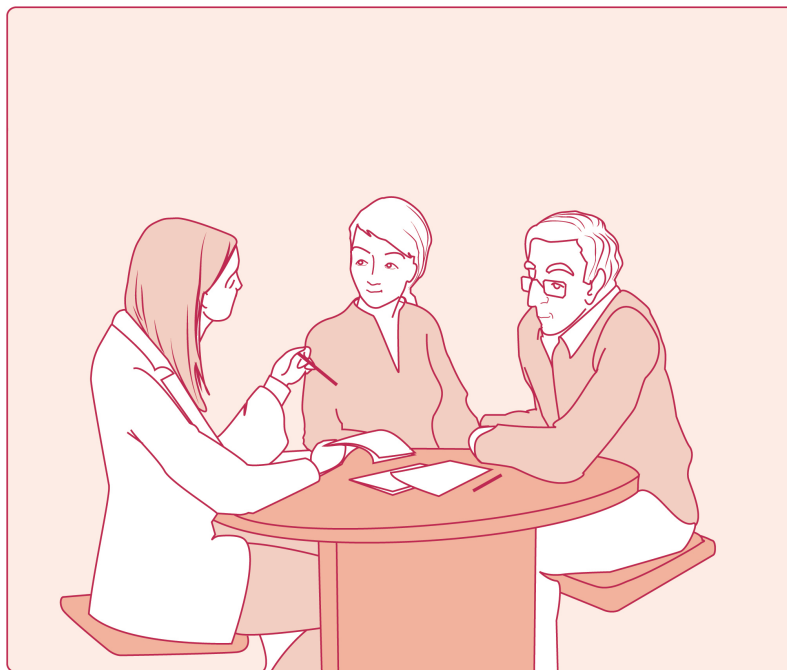
Sixth: Allows the **designation of one or two Representatives**.

- **Annex III: Acceptance of the person who will act as your Representative**
-This annex has to be **signed** by the person you have chosen to be your **Representative**.
- **Annex IV: Acceptance of the person who will act as the Substitute of your Representative**
-This annex has to be **signed** by the person who will act as the **Substitute for your Representative**.

The following is a more detailed description of each annex. You can consult each annex to find **information and suggestions** that will help you fill in the forms.

Remember

You can always ask a health professional **help** you fill in the documents.



PLEASE NOTE THAT LEGAL AND BINDING FORMS ARE IN SPANISH IN APPENDIX I.
YOU WILL HAVE TO USE THE SPANISH FORMS TO REGISTER YOUR ADVANCE HEALTH CARE DIRECTIVE.
THE REGISTRY OF ANDALUSIA ONLY ACCEPTS THE MANDATORY FORMS IN SPANISH.

Annex I: Information and Suggestions

ANNEX I APPLICATION

REGISTRATION IN THE ANDALUSIAN REGISTRY OF ADVANCE HEALTH CARE DIRECTIVES

1 PERSONAL DETAILS OF THE INDIVIDUAL MAKING THE APPLICATION

- Includes personal details.
- Only fill in the postal address for correspondence if you want the correspondence delivered to an address **other than your permanent domicile**.

2 ACCOMPANYING DOCUMENTATION

- In these boxes mark the **documents** you will submit when you attend the registration appointment.
- If you are an **emancipated minor** you will need to present the corresponding court order as proof.
- If you have been declared **mentally incompetent** you should present the corresponding court certification so that the person handling your application can establish that the order doesn't bar you from making an Advance Health Care Directive.

3 IF THE APPLICANT CANNOT SIGN

- If for some reason you are unable to sign, for instance your arm is in a cast, another person can sign for you.
- This person will be a **simple witness** to your intention to register your Advance Health Care Directive. Their personal details and signature have to be included in the appropriate box.

Very Important

This person is **not your Representative** and will **not be making any decisions about your medical treatment**. The designation of your Representative must be made in the sixth part of **Annex II**. Also, your Representative has to **express his agreement by signing Annex II**.

JUNTA DE ANDALUCIA**MINISTRY OF HEALTH**

IDENTIFICATION CODE

REGISTRATION NUMBER, DATE AND TIME

REGISTRATION IN THE ANDALUSIAN REGISTRY OF ADVANCE HEALTH CARE DIRECTIVES

DECREE../.....OF....OF.....(BOJA N°.....OF DATE.....)

1. PERSONAL DETAILS OF THE PERSON MAKING THE DIRECTIVE APPLICATION

LAST NAME AND GIVEN NAME.....DNI/NIE/PASSPORT

DATE OF BIRTH.....SEX: MALE/FEMALEADDRESS

TOWNPROVINCE.....POSTAL CODE

TELEPHONE.....FAX.....EMAIL

OTHER ADDRESS FOR CORRESPONDENCE (ONLY IF DIFFERENT FROM ABOVE).....

TOWNPROVINCE.....POSTAL CODE

TELEPHONE.....FAX.....EMAIL

2. ACCOMPANYING DOCUMENTATION

Advance Health Care Directive (Annex II)

Acceptance of the Representative, if appointed, and his or her personal identification document (Annex III)

Acceptance of the Substitute of the Representative, if appointed, and his or her personal identification document (Annex IV)

In the case of a minor, the accreditation documentation

In the case of mental incompetence, the court order declaring that incapacity

3. IN THE CASE THAT THE APPLICANT CANNOT SIGN (1)

Identification of the person who, acting as a witness, signs on the applicant's behalf

LAST NAME AND GIVEN NAME.....SEX MALE/FEMALE

DIN/NIE/PASSPORT

SIGNATURE

4. DECLARATION, AUTHORISATION, APPLICATION, PLACE DATE AND SIGNATUREI **DECLARE** under my responsibility that the details contained in this application are correct.I **AUTHORISE**, under the terms laid down in the Law 15/1999 of 13th December of Personal Data Protection:

First- The transfer of personal details included in the Advance Health Care Directive to the health professionals involved in my health care.

Second- The transfer of those details to the National Registry of Advance Directives.

4 DECLARATION, AUTHORISATION, APPLICATION, PLACE DATE AND SIGNATURE

In this box, you declare that the details you are providing **are correct**. This means that if you have given false information, any unforeseen consequences that may result will be your own responsibility.

You have also **authorised** that all the personal details included in your Directive may be **known and used by health professionals caring for you**. This will permit them to respect the wishes and preferences you have included in your Directive. You can find more information about “DATA PROTECTION” in the last box of the Annex.

You are also authorising that your details be **included in the National Registry of Advance Directives**:

- This registry contains all the advance directives from all the regional governments of Spain.
- If you make a new directive in another region, the previous one registered in Andalusia will cease to be valid. Only your latest directive will be valid.
- If you travel outside Andalusia and need medical attention, the health professionals attending you there will be able to access the information included in your directive and respect your wishes and preferences.
- Your directive is valid in all Spain's regions, so you do not need to carry a copy if travelling within Spain.
- This telematic Registry is located in Madrid at the Ministry of Health, Social Services and Equality.
- If you travel outside Spain your directive cannot be consulted, so you are recommended to carry a copy of it with you.

Finally, and most **importantly**: you are requesting the registration of your Advance Health Care Directive in the **Andalusian Registry**.

The **date and signature** should be included in this document. If you are unable to sign, a witness designated by you can sign for you.

The person attending you at the registration office **is obliged to identify him/herself** to you and record that you are capacitated to register your directive. So don't be surprised if that person asks you **questions designed to ascertain your** capacity to make such a declaration.

4. DECLARATION, AUTHORISATION, APPLICATION, PLACE DATE AND SIGNATURE (continued)

I request the registration of the attached Health Care Directive in the Registry of Advance Health Care, in accordance with the Law 5/2003 of 9th October on Advance Health Care Directives, and the Law 2/2010 of 8th April, rights and guarantees of dignity for the terminally ill, and its regulatory development.

In.....(day, month year)

Applicant or witness (1)

Signed

In my presence, following verification of the applicant's identity

REGISTAR OF THE ANDALUSIAN REGISTRY OF ADVANCE HEALTH CARE DIRECTIVES

(stamp)

Signed

(1) To be filled in if the applicant is unable to sign

PERSON IN CHARGE OF THE ANDALUSIAN REGISTRY OF ADVANCE HEALTH CARE DIRECTIVES

DATA PROTECTION

Under the Organic Law 15/1999 of 13th December regarding the Protection of Personal Data, the Regional Health Ministry informs you that the personal details obtained from the documentation/form and other attached forms are to be processed in the Andalusian Registry of Advance Health Care Directives. It also informs you that by archiving and disseminating these details, your health care preferences will be respected should you become unable to express them for yourself. In accordance with the said Law, the applicant has the right to access, rectify, cancel, or alter this document in writing at the offices of the Andalusian Registry of Advance Health Directives.

Annex II: Information and Suggestions

ANNEX II

ADVANCE HEALTH CARE DIRECTIVE

-Fill in the blank spaces.

-The **NHUSA** (Andalusian personal medical history number) will be filled in by **the person doing the registration**. This number enables electronic access to your Advance Health Care Directive through your medical history.

I STATE

Remember that as long as you are sufficiently **able to communicate** your own decisions, medical personnel will ask you directly what you wish to do in each situation and **will not consult your Advance Health Care Directive**.

I DECLARE

FIRST.- LIFE VALUES TO BE TAKEN INTO ACCOUNT AND THAT FORM THE BASIS FOR MY DECISIONS AND PREFERENCES

In this section you can, if you wish, include those values that you consider important and which **support your decisions and preferences** during illness and death.

These are the **values** that you would like health professionals to take into account when they make decisions related to possible **treatments or health care**.

Here are some suggested **examples** of values that could be important for you to include in your Declaration if you so decide:

- **Be able to communicate** in some way with my family and friends
- Be sufficiently **conscious** to be aware of my surroundings
- Be able to carry out my **personal hygiene**
- **Feed** myself without **artificial means**
- **Move** on my own with minimum help
- **Live independently** without being permanently dependent on life support equipment
- Be reasonably **pain free**
- To be looked after in **my own home** by my loved ones
- To be able to stay in **my own home** for my last days
- You can include phrases such as:

“I want my treatments to be limited to those that maintain my **comfort** and relieve me **from any physical pain** or psychological suffering that may be caused by my illness even if the treatment may hasten my death.”

“I do not want treatments or tests to be continued after it is clear that I will not regain consciousness.”

It is very important if you decide to appoint a Representative and Substitute that you **speak to them about these wishes**. You are also recommended to speak to **your family and to the health professionals** that are attending you.

JUNTA DE ANDALUCIA

MINISTRY OF HEALTH

IDENTIFICATION CODE

REGISTRATION Nº, DATE AND TIME

DECLARATION OF ADVANCE HEALTH CARE DIRECTIVE

Decree ../.....of....of.....(BOJA Nº..... dated

I, Mr/Mrs/Miss/Ms.....with DNI/NIE/Passport Number.....

NUHSA Number.....

Inscription date.....

I STATE:

That with this Advance Health Care Declaration I am expressing the values and preferences which should be respected in my health care if I am unable to personally express my wishes

I DECLARE:**FIRST.- VALUES WHICH SHOULD BE TAKEN INTO ACCOUNT AND WHICH FORM THE BASIS FOR MY DECISIONS AND PREFERENCES**

If my clinical condition does not allow me to make my wishes known, I would like the decisions made by health professionals on my behalf take into account the following values:

SECOND.- CLINICAL SITUATIONS IN WHICH I WANT THIS DOCUMENT TO BE USED

This part of the document starts with your general declaration which explains why you are making this Advance Health Care Directive. You will note that, in principle, it **will NOT be applied** in **acute situations** when treatment could save your life - a road traffic accident, an acute heart attack, a severe infection, a recently diagnosed cancer etc - unless you specifically express the contrary in the fifth part. The Directive will only be applied in **grave and irreversible conditions** where the possibility of recovery is minimal or unlikely.

As well as this general declaration, in this part of your Advance Health Care Directive you can also include any specific clinical condition that you wish to be considered.

For example you could include some clinical conditions that can develop into **serious physical deterioration**:

- **Brain damage** -severe or irreversible (irreversible coma, permanent vegetative state, minimal consciousness).
- **Terminal phase** of illness.
- **Dying phase** of illness.
- **Advanced stage of a degenerative nervous system illness.**
- **Advanced stage of a degenerative neuromuscular system illness.**
- Advanced stage of degenerative **dementia**.
- Advanced stage of **immunodeficiency**.

At the end of this guide, you can consult a **list of definitions** of some of these clinical conditions.

Pregnant women, who could find themselves in situations under which the Directive could be applied, can also express their personal preferences:

- You can state that you wish to be kept alive using **life support systems** only until the foetus is mature enough to be born.
- You can also state your desire to donate blood from the umbilical cord so that your attending health care professionals can act accordingly. To become a donor of umbilical cord blood it is not sufficient for this to be included in your Advance Health Care Directive. You have to contact one of Spain's umbilical cord blood banks. All the information about how to do this can be found on the **SAS web page**:

<http://www.sas.junta-andalucia.es>

SECOND.- CLINICAL SITUATIONS IN WHICH I WANT THIS DOCUMENT TO BE USED

This document should be taken into consideration under clinical conditions in which there is no possibility of recovery; could cause me great physical or mental deterioration; or are incompatible with the instructions and values expressed in the Directive.

Following are some specific clinical situations that I wish to apply to this document.

NON-OFFICIAL

THIRD.- INDICATIONS FOR THE FOLLOWING CLINICAL CARE ACTIONS

Different **clinical care actions**, which could be appropriate for you in the future, are included in this section. In principle, health care professionals will decide whether or not the actions are indicated, depending on the specific moment and circumstances surrounding each case.

You will only be able to make decisions regarding those actions that would be indicated. This means that it will not be possible to request an action that is not indicated.

If the health personnel think that the actions could be useful for your situation, in this part of the Directive you can:

- Give your **consent** to receive the clinical care action proposed (mark **I WISH TO RECEIVE IT**).
- **Reject** receiving the clinical care action proposed (mark **I DO NOT WISH TO RECEIVE IT**).
- **Decide not to express your opinion** in that regard (mark **I HAVE NOT DECIDED**), perhaps because at that moment you are not sure or perhaps because you would prefer that your Representative or family decide in that situation.

While you may reject specific health actions, health professionals will always conduct the clinical interventions necessary to **guarantee your adequate care and comfort**. Rejecting specific measures will not diminish the quality of care and attention you will receive.

The **GLOSSARY OF TERMS USED** (page 29)
tells you what each of the clinical care actions
suggested in this section consists of.

OTHER CLINICAL CARE ACTIONS THAT I WISH TO RECEIVE, AS LONG AS THE ACTION IS CLINICALLY INDICATED.

In this space you can, if you wish, reflect other **clinical care actions** not included in the previous section and on which you would like to make your preferences known.

For example, you could include more specific preferences about blood transfusions.

You can also include preferences regarding, for example, your initial acceptance regarding the use of certain techniques during a specific trial period and your desire, if no beneficial results can be seen at the end of that period, for them to be withdrawn.

IDENTIFICATION CODE

THIRD.- INDICATIONS ON THE FOLLOWING CLINICAL CARE ACTIONS

Taking into account the first and second parts of this Directive, and providing the following actions are clinically indicated, these are my preferences:

Blood Transfusion

I want to receive it I do not want to receive it I have not decided

Parenteral artificial feeding (nutrition via intravenous drip)

I wish to receive it I do not wish to receive it I have not decided

Artificial feeding via a gastrostomy tube (tube placed directly into the stomach)

I wish to receive it I do not wish to receive it I have not decided

Artificial feeding via a naso-gastric tube (tube introduced through the nose to reach the stomach)

I wish to receive it I do not wish to receive it I have not decided

Hydration by intravenous drip

I wish to receive it I do not wish to receive it I have not decided

Techniques for renal dialysis

I wish to receive it I do not wish to receive it I have not decided

Artificial respirator

I wish to receive it I do not wish to receive it I have not decided

Cardiopulmonary resuscitation

I wish to receive it I do not wish to receive it I have not decided

Palliative sedation

I wish to receive it I do not wish to receive it I have not decided

FOURTH. – ORGAN AND TISSUE DONATION

Transplanting organs and tissues is an **act of generosity** towards seriously ill patients. For many their survival depends on our compassion. Organ extraction can **only** be done when the patient has died. You can find detailed information about organ donations and transplants at:



Andalusian Autonomous Transplant Coordination

<http://bit.ly/fACqbs>

Telephone: 901 40 00 43 (8 am -3 pm).

National transplant coordination

<http://www.ont.es>

Telephone: 902 300 224 (24 hours).

Processes that begin with complete, irreversible brain damage or cardio-respiratory arrest can often lead to death of the physical body. In the first case the donor's brain is dead and in the latter the donor's heart stops beating. When brain death occurs, the body's respiratory function ceases and **artificial respiratory support** is needed to maintain the organs viable until their extraction.

The sentence in the text that says, "I accept the application of necessary procedures to certify death and maintain the organs' viability until they are removed", means **that your organs and tissues will only be extracted if relevant medical conditions are met in compliance with existing legislation**. You should be aware that it is not always possible to extract organs when someone dies.

If you are **not sure** about your wishes and preferences and want your Representative to make the decision, you can mark the box **I HAVE NOT DECIDED**.

If you want to donate your **body to science** and research, you can leave this instruction in the space in the fifth part of the form. To donate your body you have to contact the medical faculty closest to where you live and they will explain the procedure that has to be followed once you have died.

IMPORTANT:

You should be aware that if you donate your body to science you **cannot be** an organ or tissue donor.

You are advised to **discuss the contents** of this section with your **Representative** and **family** so that they are aware of your wishes and preferences.

FIFTH.– OTHER CONSIDERATIONS AND PREFERENCES THAT SHOULD BE TAKEN INTO ACCOUNT

Use the blank space that follows to write other specific considerations and preferences that may not have been included in this document and that you consider important.

You can also stipulate your wishes for **religious assistance** or the people you want to be with you in your last moments. Some organisations and religions recommend to their members a specific model of Living Will. It can be included in this space.

FOURTH.– ORGAN AND TISSUE DONATION

I accept that the necessary procedures may be applied to certify death and maintain the organs' viability until they are removed. My wish regarding organ and tissue donation is:

Donate organs

Yes No I have not decided

Donate tissues

Yes No I have not decided

Considerations about organ and tissue donations:

FIFTH.– OTHER CONSIDERATIONS AND PREFERENCES THAT SHOULD BE TAKEN INTO ACCOUNT

Finally, I want the following clinical decisions to be taken into account:

SIXTH .– DESIGNATION OF REPRESENTATIVE/S:

You can **appoint a Representative** to give consent to or refuse clinical actions **in your name** when you are unable to express your wishes. You can also appoint a **Substitute** for your Representative, that is to say, another person to act as a second Representative in case the first one, for any reason, cannot act on your behalf when required. **What you state in your Advance Health Care Directive overrides what your Representative may indicate.**

You do not have to appoint a Representative, nevertheless, you are **recommended to do so**. Although in previous parts of your Directive you attempt to foresee a variety of clinical situations and express many of your preferences, it is practically impossible to predict all that could happen. Medicine is complex and you could be in a clinical situation that is not contemplated in your Directive and in which health professionals and family members are not sure how to act. This is why you should choose a person that knows your thoughts and to whom you have explained your preferences and values. They can then make decisions on your behalf **according to the values you have expressed** in the first part of the Directive.

It is very important to think carefully about who you name as your Representative. That person should be someone in your **complete confidence** with whom you have discussed your preferences and wishes. He or she does not necessarily have to be a family member, it can be a friend.

We do recommend that you **tell your family** the names of your appointed Representatives. You should be aware that the decisions made by your Representative or Substitute about your Advance Health Care Directive will **take priority over the opinions of your family**. Therefore, to avoid conflicts it is important that everyone knows who you have appointed as your Representative and Substitute.

The persons appointed As Representatives or Substitutes have to give their consent to being named. They have to sign in Annexes III and IV and it would also be convenient if they know each other.

In the **blank space** you can state the **functions and limitations** of the persons named as **Representative and Substitute** and they should abide by these.

SIXTH – DESIGNATION OF REPRESENTATIVE/S

I wish to name

as the person who will act as my Representative to ensure that my wishes are carried out in the clinical situations included in this Directive and make appropriate decisions, taking into account my life values, in those situations that are not explicitly expressed.

Mr/Mrs/Miss/Ms.....DNI/NIE/Passport.....

Date of birth: day.....month.....year

SEX male female

Address:

.....

In case the person appointed as my Representative is unavailable, I also wish to name a Substitute. This Substitute has the same authority and limitations as my Representative.

Mr/Mrs/Miss/Ms.....DNI/NIE/Passport.....

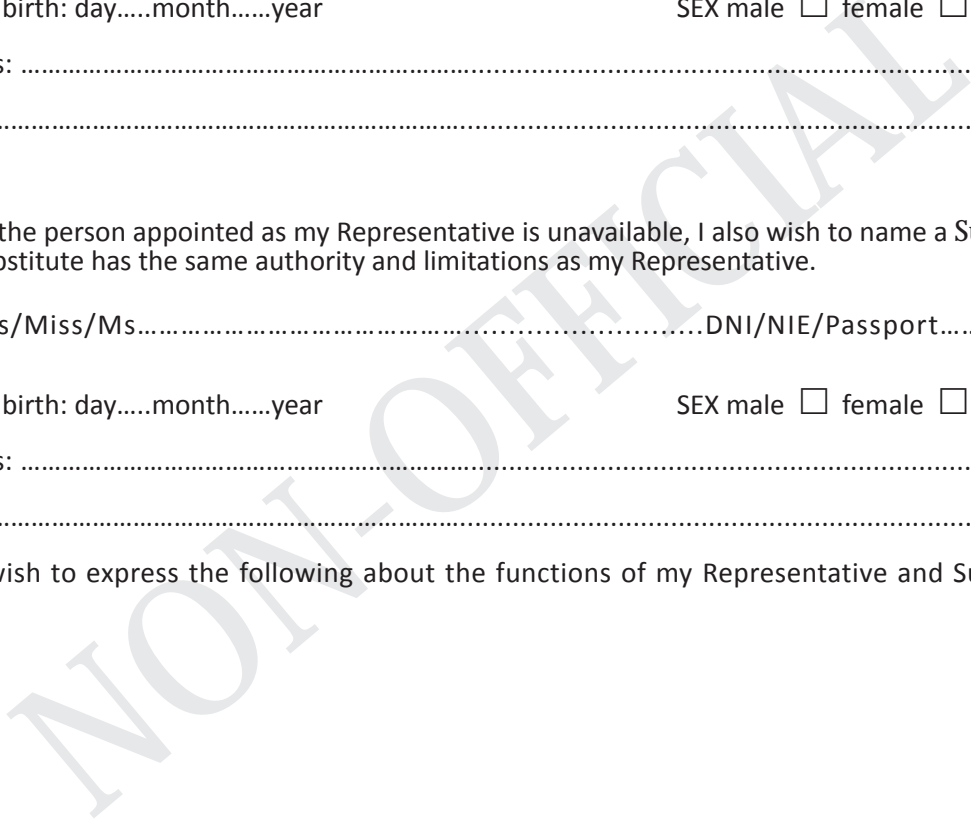
Date of birth: day.....month.....year

SEX male female

Address:

.....

I also wish to express the following about the functions of my Representative and Substitute:



SEVENTH.– PLACE AND DATE OF VALIDATION

Filling in and signing this part lends **validity** to the rest of the document's contents.

The person in the registry office will enter all the details contained in your Directive into a computer file where it will be recorded. It will then be printed. **This is the document which you will have to sign and place your initial on all pages.**

From the moment your document is inscribed in the **Andalusian Registry of Advance Health Care Directives it will become valid** and accessible through your **clinical history**.

The health care directive you have registered in the Andalusian Registry of Advance Health Care Directives is also registered in the **National Registry of Advance Directives**.

Andalusian health professionals who attend you can, at any time, consult the contents of your Directive via your digital medical history, by telephone, via "Salud Responde" or through the Regional Health Ministry's web page. If the Web page is used, the professionals have to identify themselves using their digital certification. This means that not all professionals have access to your Directive. Only those attending you can gain access by following a **protocol to protect confidentiality**.

It is advisable to give a printed copy of your Advance Health Care Directive to the doctors that normally look after you so that they have prior knowledge about it.

Health professionals caring for you in the rest of Spain can at any time, following the protocol established in their region, consult the contents of your Directive in the National Registry of Advance Directives.

Remember

- You can **change** your Directive **whenever** you want.
- You are advised to keep **details up to date** to facilitate the localisation of your Representatives.

SEVENTH.– PLACE AND DATE OF VALIDATION

On.....day⁽¹⁾month.....Year.....

Signature and initials ⁽²⁾

Signed.....

(1) Write the date – not numerals

(2) The document has to be signed and each page initialed

DATA PROTECTION

Under the Organic Law 15/1999 of 13th December regarding the Protection of Personal Data, the Regional Health Ministry informs you that the personal details obtained from the documentation/form and other attached forms are to be processed in the Andalusian Registry of Advance Health Care Directives. It also informs you that by archiving and disseminating these details, your health care preferences will be respected should you become unable to express them for yourself. In accordance

Annex III: Information and Suggestions

ANNEX III

ACCEPTANCE OF THE PERSON WHO WILL ACT AS YOUR REPRESENTATIVE

Remember

The person acting as Representative **does not have to be a family member.**

It is **imperative** that your Representative gives **written consent** in this acceptance document. If the sixth part of Annex III is not signed their designation as your Representative will not be valid.

Verification of Representative's identity to the civil servant registering the health care directive can be done in two ways

- By permitting the civil servant to confirm his or her identity through an **identity verification system**. If this box is marked your Representative does not have to produce a photocopy of their DNI because the registrar can access it online.
- If the above system is not used, an **authenticated copy of DNI or NIE** has to be provided to verify his or her identity.

This process can also be carried out via **internet** using the **digital certificate** if the person signing the advance health care directive has completed an online pre-inscription and the name of the Representative appears in that pre-inscription. If Representatives have a digital signature the whole procedure can be done online by signing Annexes III and VI via the **web page**:

<https://www.juntadeandalucia.es/salud/rv2/inicioCiudadania.action>

Once the Directive has been registered, the Representatives can access and consult the Directive of the represented person, through the menu on the website titled, "REPRESENTACIÓN".

It is very important that the Representative be **completely aware of the functions being assumed** when signing the acceptance document. The document includes a reminder of the Representative's functions.

It is highly advisable that you and your Representative have **spoken together** about the function of your Directive and your **values, wishes and preferences**. It may be easier if these conversations **take place with a health professional** that can explain any questions or resolve any doubts you may have, clarifying different clinical situations etc.

MINISTRY OF HEALTH

IDENTIFICATION CODE

REGISTRATION Nº, DATE AND TIME

ACCEPTANCE OF THE PERSON WHO WILL ACT AS YOUR REPRESENTATIVE

Decree ../.....Of....Of.....(BOJA Nº.....Of date.....)

Last name and given name.....DNI/NIE/Passport.....

Date of birth..... Sex: malefemale address.....

Town.....Province.....postal code.....

Country..... contact telephone numbers.....Email.....

I agree to represent:

Last name and given name.....DNI/NIE/Passport.....

Date of birth..... Sex: malefemale address.....

Town.....Province.....postal code.....

Country..... contact telephone numbers.....Email.....

I consent to my identification details being confirmed by the identity verification system.

I do not consent to my identification details being confirmed by the identity verification system. I am supplying an authenticated copy of my DNI/NIE.

I accept the functions of:

- Always finding the greatest benefit and dignity for the person I represent.
- Ensuring that the instructions about clinical situations included in their Directive by the person I represent are carried out.
- Taking into account the values and vital options contained in the Directive of the person I represent, and making their wishes clear in those clinical situations not explicitly described in the Directive.
- Respecting the indications of the person I represent as to my functions as Representative.

PLACE AND TIME

In.....day⁽¹⁾month.....Year.....

Signed.....

(1) Write the date – not numerals

DATA PROTECTION

Under the Organic Law 15/1999 of 13th December regarding the Protection of Personal Data, the Regional Health Ministry informs you that the personal details obtained from the documentation/form and other attached forms are to be processed in the Andalusian Registry of Advance Health Care Directives. It also informs you that by archiving and disseminating these details, your health care preferences will be respected should you become unable to express them for yourself. In accordance with the said Law, the applicant has the right to access, rectify, cancel, or alter this document in writing at the offices of the Andalusian Registry of Advance Health Directives.

Annex IV: Information and Suggestions

ANNEX IV

ACCEPTANCE OF THE PERSON WHO WILL ACT AS THE SUBSTITUTE OF YOUR REPRESENTATIVE

As is the case with your Representative, the person substituting for your Representative can be anyone. He or she **does not have to be a family member**.

The following **should be** included in this Annex:

- The name and personal details of the person who will act as the **Substitute** of your Representative
- The name and personal details of the **Representative** to be substituted
- The name and personal details of the person that will be represented by both Representative and Substitute

The person substituting for the Representative must also give his/her **written consent** in this acceptance document. As in Annex III, either of the two methods of identification can be used.

In the same way as the Representative, the Substitute has to **be fully aware of the functions they assume** when signing the document.

Your Representative and Substitute are recommended to have discussed their functions as well as **the contents** of your Directive, particularly your **values, wishes and preferences**. The participation of the Representative in these conversations would also be of value.

As mentioned earlier, it could be simpler if all these conversations take place with the input of a **health professional** to explain doubts and discuss different clinical situations etc.

MINISTRY OF HEALTH

IDENTIFICATION CODE

REGISTRATION Nº, DATE AND TIME

ACCEPTANCE OF THE PERSON WHO WILL ACT AS THE SUBSTITUTE OF YOUR REPRESENTATIVE

Decree ../.....Of....Of.....(BOJA Nº.....Of date.....)

Last name and given name.....DNI/NIE/Passport.....

Date of birth..... Sex: malefemale address.....

Town.....Province.....postal code.....

Country..... contact telephone numbers.....Email.....

I agree to substitute:

Last name and given name.....DNI/NIE/Passport.....

Date of birth..... Sex: malefemale address.....

Town.....Province.....postal code.....

Country..... contact telephone numbers.....Email.....

I consent to my identification details being confirmed by the identity verification system.

I do not consent to my identification details being confirmed by the identity verification system. I am supplying an authenticated copy of my DNI/NIE.I accept the functions of:

- Always finding the greatest benefit and dignity for the person I represent.
- Ensuring that the instructions about clinical situations included in their Directive by the person I represent are carried out.
- Taking into account the values and vital options contained in the Directive of the person I represent, and making their wishes clear in those clinical situations not explicitly described in the Directive.
- Respecting the indications of the person I represent regarding my functions as Representative.

PLACE AND TIME

In.....day⁽¹⁾month.....Year.....

Signed.....

(1) Write the date – not numerals

DATA PROTECTION

Under the Organic Law 15/1999 of 13th December regarding the Protection of Personal Data, the Regional Health Ministry informs you that the personal details obtained from the documentation/form and other attached forms are to be processed in the Andalusian Registry of Advance Health Care Directives. It also informs you that by archiving and disseminating these details, your health care preferences will be respected should you become unable to express them for yourself. In accordance with the said Law, the applicant has the right to access, rectify, cancel, or alter this document in writing at the offices of the Andalusian Registry of Advance Health Directives.

Glossary of Terms

Here are **definitions** of some terms that have not been defined in this guide and which could be useful when making your Advance Health Care Directive.

Other terms which could be useful are defined in **Article 5 of the 2/2020 Law of Protection of the Rights and Guarantees of Dignity of the Dying Person**.

LIVING WILL:

Is a synonym for Advance Health Care Directive.

PREVIOUS INSTRUCTIONS:

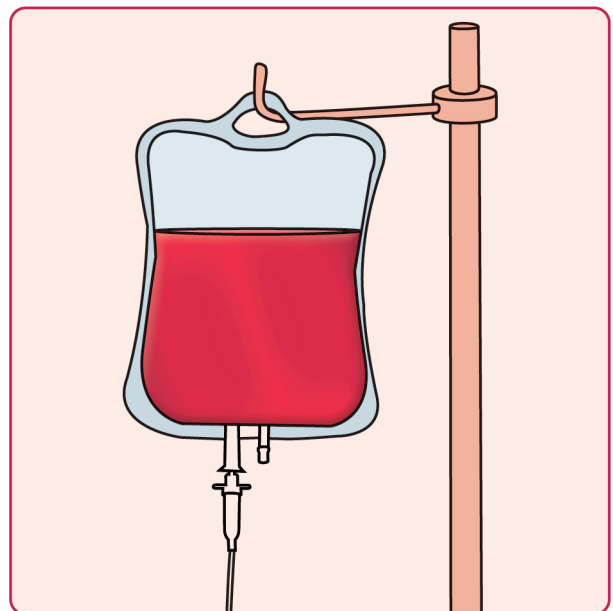
Is a synonym for Advance Health Care Directive. This is the name given to the document in other regions of Spain

BLOOD TRANSFUSION:

Donating whole blood or specific components of blood such as red blood cells, platelets or plasma intravenously.

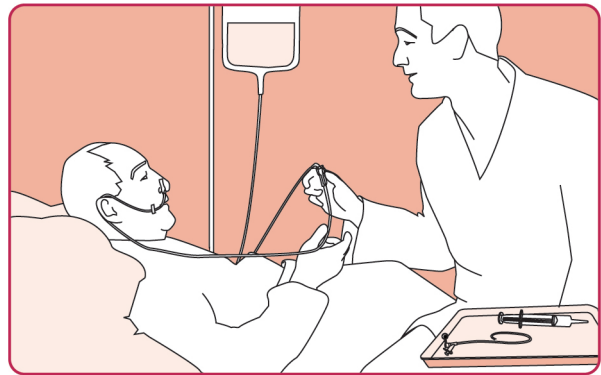
Transfusions are given when someone has lost blood in a surgical operation, when required as part of a specific treatment, or in illnesses related to anemia.

Some people who know that they will need blood during an operation will donate their own blood beforehand to be used when required (**self-donation**).



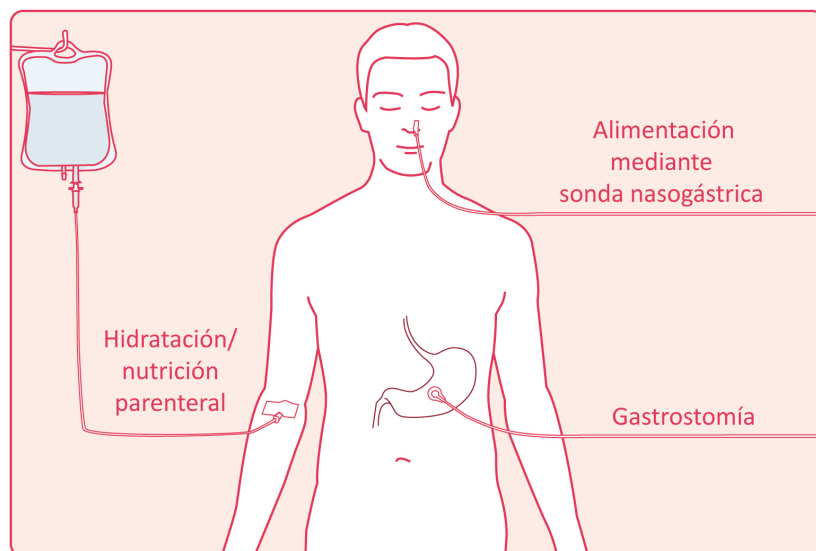
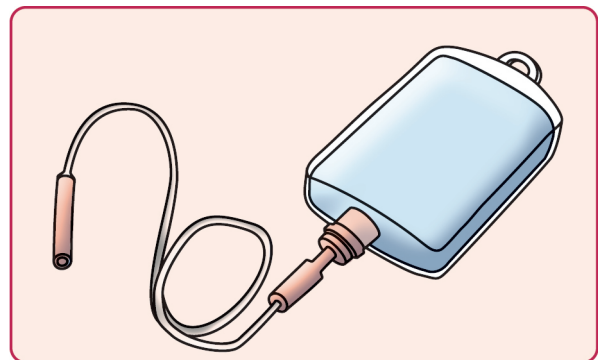
Nutrition via nasogastric tube (a tube introduced via the nose which reaches the stomach):

Nutrients and fluids are given by a **tube** which is passed through the patient's **nose and throat** to reach their **stomach**. The introduction of the tube can be difficult and can be unpleasant for the patient. It is a procedure which should be considered as a **temporary** measure.



Hydration by intravenous drip:

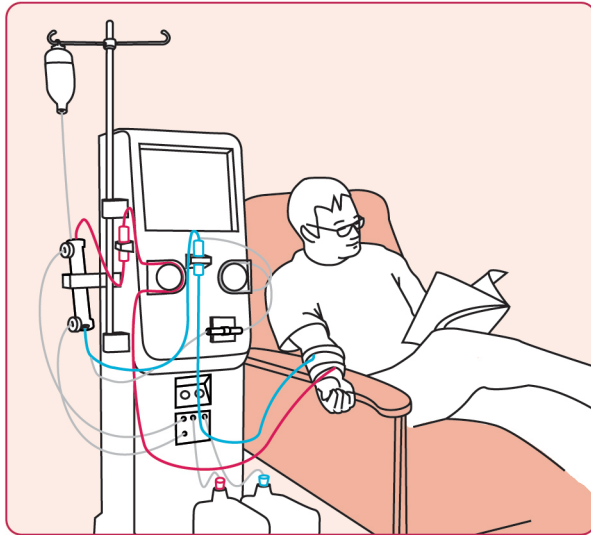
In this case, **only fluids** are given to the patient, not nutrients. **Normal fluids** (saline or glucose) are used via the normal intravenous route. It is a procedure which is temporary and of limited effect.



TECHNIQUES OF RENAL DIALYSIS:

These include a group of techniques that act as a **substitute for the kidneys' work** and sometimes the **liver**. They consist of **filtering the patient's blood to eliminate dangerous waste products** from the body, as well as excess water and salt.

Amongst these techniques are:



•Haemodialysis (or simply dialysis):

Cleans and filters the blood by passing the blood through a **machine**. The cleaned blood is then returned to the body.

The haemodialysis sessions are done at a **dialysis centre** three times a week for 3 or 4 hours.



•Peritoneal dialysis:

Uses the inner membrane of the abdomen called the **peritoneal membrane** to filter the blood. Liquid is injected into the abdomen and this liquid collects the blood's waste products. After a few hours the liquid is drained, and with it the body's waste products are eliminated. People are able to **learn to do this themselves** without needing to go to a clinical centre. People receiving continuous peritoneal dialysis as outpatients, the most common type of peritoneal dialysis, perform the technique four times a day. There is another form of peritoneal dialysis that employs an automatic machine during the night.

•Other techniques:

Hemofiltration or ultrafiltration are used for critical patients in intensive care units.

ARTIFICIAL RESPIRATION OR MECHANICAL VENTILATION:

This is a **machine that helps the lungs function**. The machine, called a respirator, supplies air to the lungs. The respirator is connected by a **tube through the nose or mouth** to the trachea.

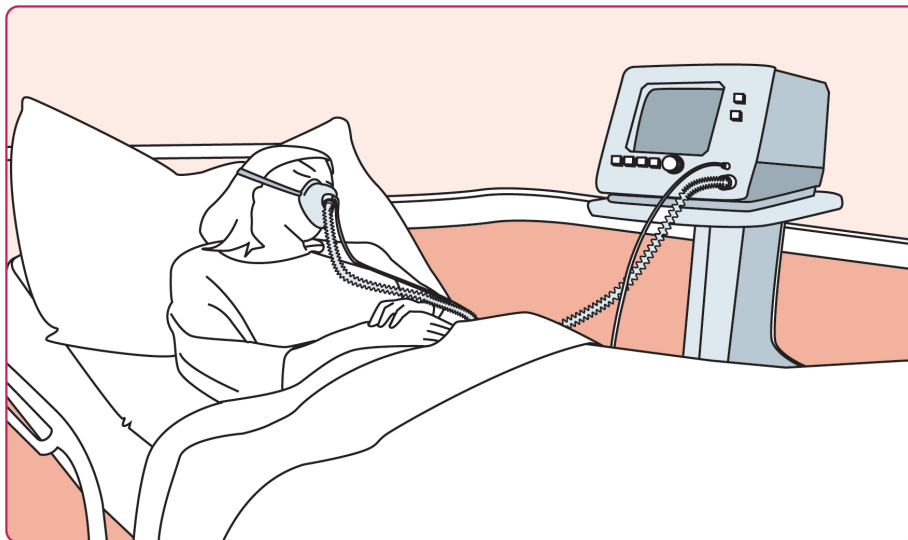
This treatment is normally given in a hospital, but not exclusively. In some cases people can be at home with a respirator.

It is normally used until the patient can breathe by himself. This is a **temporary measure in acute situations** such as accidents, heart attacks or severe infections.

In some cases people are unable to breathe spontaneously again. This can happen in many **grave illnesses** e.g. patients with progressive illnesses affecting their nerves or muscles. In these cases the **respirator is not curative** and the patient is dependent on the respirator to continue living.

In this situation some people can maintain a **quality of life** they consider to be adequate and sufficient, but others do not always want to live connected to a respirator.

In **terminal situations**, or when the patient is dying, being connected to a respirator only prolongs the process until other parts of the body's system fails. Therefore, **it does not give any additional benefit** to the patient and is **not indicated**.

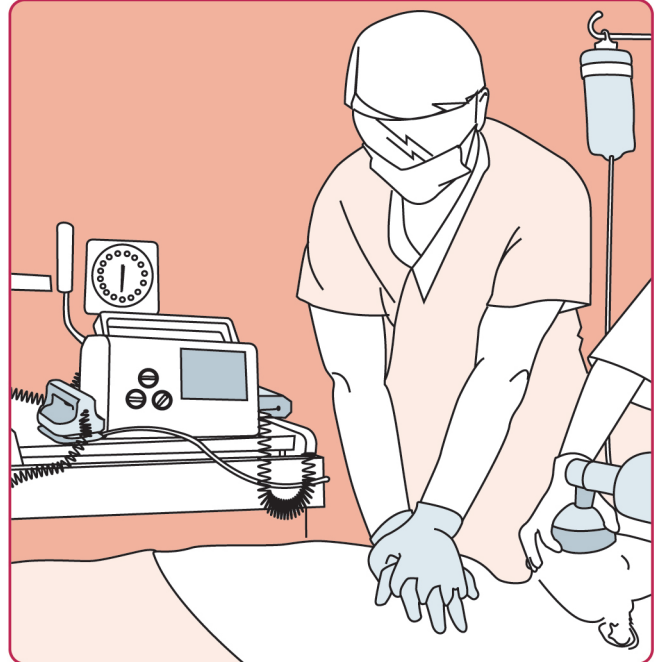


CARDIOPULMONARY RESUSCITATION (CPR):

Is a **sequence of actions** done by health professionals **when the heart stops beating or the patient stops breathing**. CPR can help **reestablish the heartbeat and regular breathing**.

Sometimes it only involves mouth-to-mouth **resuscitation**, but more frequently it includes:

- **Massage on the chest** to imitate the function of the heart and help the blood to continue circulating.
- **Applying electric current** to try to get the heart beating again (defibrillation).
- **Giving medication** to stimulate the heart.



When CPR is used quickly in response to cardiac arrest, such as in cases involving a heart attack, an accident or drowning it **can save lives**. However, **it is not indicated in the terminally ill** or the dying patient.

PALLIATIVE SEDATION:

This consists of **administering medications** in the doses and combinations necessary to **reduce the level of consciousness** in patients in the terminal stage. It is sometimes needed to alleviate certain refractory symptoms that produce suffering e.g. uncontrollable **pain** or intense **difficulty in breathing**.

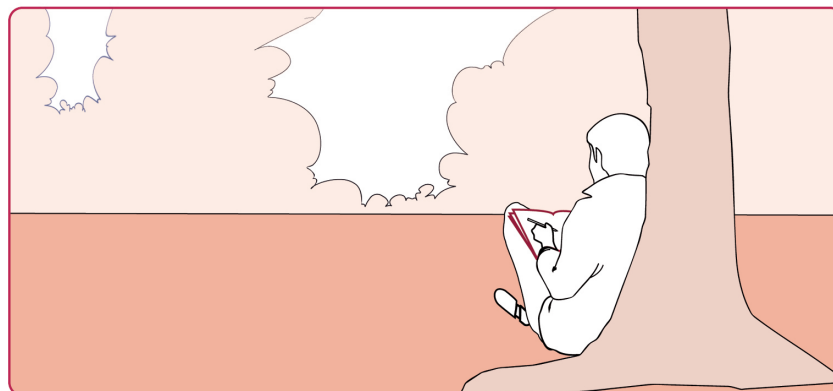
This treatment may **shorten life**, which is why it is important that both you and your family know about it.

IMPAIRED CAPACITY OF CONSENT:

Refers to a situation in which people are **unable to understand or lack the will** to manage their own lives autonomously, not necessarily including a judicial finding of incapacity e.g. the person is **unconscious, in a coma or sleeping due to a general anesthetic**.

LIFE VALUES:

The **ideals and beliefs** that a person has which give meaning to her **life** and determine her decisions and preferences regarding health processes, illness and death.



LIFE SUPPORT SYSTEM:

Is an intervention, technique or health procedure to maintain, reestablish or replace a vital body function and so prolong the patient's life e.g. substituting an artificial respirator for normal breathing. These measures replace or support the vital function that has failed. Sometimes they are used to give time for the person to recover from a curable or treatable condition. But the use of life-support systems **cannot cure the illness**.

Sometimes the body will never recover its normal function without using a life-support system. The illness progresses and **recovery becomes more unlikely**. In these cases the measures cease to be meaningful because they do not help to cure the patient. This is the time to **pose the question of not using** or withdrawing the life support.

TERMINAL SITUATION:

This refers to an **advanced, incurable and progressive illness** with no reasonable possibility of responding to specific treatments. The patient has a **limited life expectancy** and can have intense and changeable symptoms that require specific palliative care.

PALLIATIVE CARE:

Is a coordinated group of **comprehensive health interventions** aimed at **improving the quality of life** of patients and family who are facing the problems associated with a terminal illness. Palliative care **alleviates and prevents** suffering by identifying, evaluating and treating pain and other physical and psychological symptoms.

REFRACTORY SYMPTOM:

Is a symptom that does **not respond to the usual appropriate treatment**. **Reduced consciousness** using **palliative sedation** is needed to **control it**.

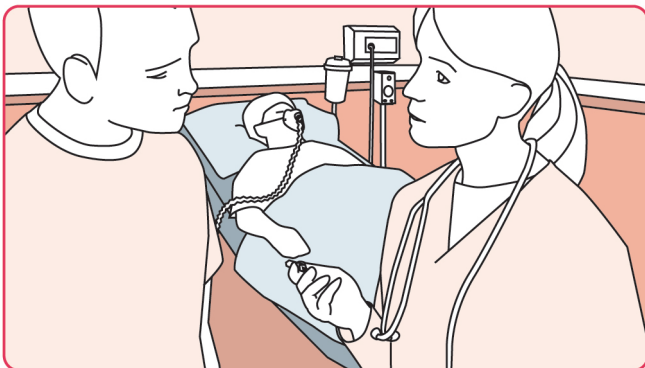
DEATH AGONY / DYING PROCESS:

Is the **gradual phase that precedes death**. Its clinical characteristics include **severe physical deterioration**, extreme weakness, changes in cognition and consciousness, difficulty in taking anything by mouth and a **prognosis of death within a few days**.

PERMANENT VEGETATIVE STATE:

Is an **irreversible coma** in which the patient, although alive, is unconscious and **unable to communicate** with their surroundings or other people.

It is irreversible because the patient never recovers his or her former state. It is usually caused by a severe illness that only permits limited cerebral function. Sometimes the patient can open her eyes or move her arms and legs but these are involuntary, never conscious, movements.



People in this state can survive for years in a totally irreversible unconscious state. They normally need artificial nutrition and hydration and sometimes they require artificial respiration.

BRAIN DEATH:

This is a clinical situation in which the patient has **completely lost all brain function**, both voluntary and involuntary. Although with the help of medical devices or drugs the heart may still beat automatically for a time, death has occurred. This is the moment when organs can be taken from the dead patient.

More information about Advance Health Care Directives

WHERE CAN I GET MORE INFORMATION ABOUT ADVANCE HEALTH CARE DIRECTIVES?

Salud Responde



Web: Consejería de Salud de la Junta de Andalucía



<https://www.juntadeandalucia.es/salud/rv2/inicioCiudadania.action>



LEGISLATION REGULATING ADVANCE HEALTH CARE DIRECTIVES

In Spain

LEY 41/2002, de 14 de noviembre, básica reguladora de la autonomía del paciente y de los derechos y obligaciones en materia de información y documentación clínica.
BOE 274 de 15/11/2002.

REAL DECRETO 124/2007, de 2 de febrero, por el que se regula el Registro nacional de instrucciones previas y el correspondiente fichero automatizado de datos de carácter personal.
BOE 40 de 15/02/2007.

More information: [Portal del Boletín Oficial del Estado](http://www.boe.es/):



<http://www.boe.es/>

In Andalusia

LEY 5/2003, de 9 de octubre, de Declaración de Voluntad Vital Anticipada.
BOJA 210 de 31/10/2003 (algunos artículos modificados por la Ley 2/2010).

LEY ORGÁNICA 2/2007, de 19 de marzo, de reforma del Estatuto de Autonomía para Andalucía.
BOE 68 de 20/03/2007.

LEY 2/2010, de 8 de abril, de Derechos y Garantías de la Dignidad de la Persona en el Proceso de Muerte. BOJA 88 de 07/05/2010. [Law 2/2010, dated 8th April, on Personal Rights and Guarantees to die in dignity].

DECRETO 59/2012, de 13 de marzo, por el que se regula la organización y funcionamiento del Registro de Voluntades Vitales Anticipadas de Andalucía. BOJA 59 de 26/03/2012

More information: [Boletín Oficial de la Junta de Andalucía](http://www.juntadeandalucia.es/boja/boletines/)



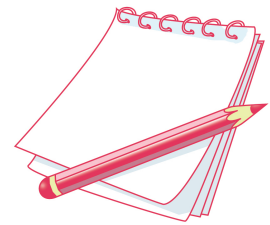
<http://www.juntadeandalucia.es/boja/boletines/>

Notes

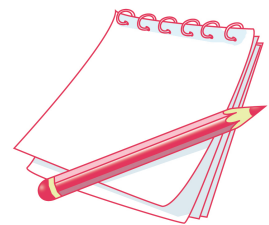
Note here which subjects you would like to consult with health professionals regarding your Advance Health Care Directive



Note here which subjects you would like to consult with your Representative/s about your Advance Health Care Directive



Note here which subjects you would like to consult with the person registering your Advance Health Care Directive



APPENDIX I

Official Advance Health Care Directive form in Andalusia

PLEASE NOTE THAT LEGAL AND BINDING FORMS ARE IN SPANISH.

YOU WILL HAVE TO USE THE SPANISH FORMS TO REGISTER YOUR ADVANCE HEALTH CARE DIRECTIVE.

THE REGISTRY OF ANDALUSIA ONLY ACCEPTS THE MANDATORY FORMS IN SPANISH.

CÓDIGO IDENTIFICATIVO

Nº REGISTRO, FECHA Y HORA

SOLICITUD

INSCRIPCIÓN EN EL REGISTRO DE VOLUNTADES VITALES ANTICIPADAS DE ANDALUCÍA

Decreto / de de (BOJA nº de fecha)

1 DATOS DE LA PERSONA OTORGANTE DE LA DECLARACIÓN / SOLICITANTE			
APELLIDOS Y NOMBRE			DNI/NIE/PASAPORTE Nº
FECHA DE NACIMIENTO	SEXO <input type="checkbox"/> HOMBRE <input type="checkbox"/> MUJER	DOMICILIO	
LOCALIDAD	PROVINCIA:	CÓDIGO POSTAL	
TELÉFONO:	FAX:	CORREO ELECTRÓNICO:	
DOMICILIO A EFECTOS DE NOTIFICACIÓN (Sólo si es distinto del anterior)			
LOCALIDAD	PROVINCIA:	CÓDIGO POSTAL	
TELÉFONO:	FAX:	CORREO ELECTRÓNICO:	

2 DOCUMENTACIÓN ADJUNTA
<input type="checkbox"/> Declaración de voluntad vital anticipada. (Anexo II) <input type="checkbox"/> Aceptación de la persona representante y, en su caso, documento acreditativo de su personalidad. (Anexo III) <input type="checkbox"/> Aceptación de la persona sustituta del representante, y en su caso, documento acreditativo de su personalidad. (Anexo IV) <input type="checkbox"/> En caso de persona menor de edad emancipada, documento que acredite la emancipación. <input type="checkbox"/> En caso de persona incapacitada judicialmente, resolución judicial de incapacitación.

3 EN CASO DE QUE LA PERSONA OTORGANTE NO PUEDA FIRMAR (1)	
Identificación de la persona que ejerce de testigo que firma a su ruego	
APELLIDOS Y NOMBRE	SEXO <input type="checkbox"/> HOMBRE <input type="checkbox"/> MUJER
DNI / PASAPORTE	
FIRMA	

4 DECLARACIÓN, AUTORIZACIÓN, SOLICITUD, LUGAR, FECHA Y FIRMA
<p>DECLARO bajo mi responsabilidad que son ciertos cuantos datos figuran en la presente solicitud.</p> <p>AUTORIZO, en los términos que establece la Ley Orgánica 15/1999, de 13 de diciembre, de Protección de Datos de Carácter Personal:</p> <p>Primero.- La cesión de los datos de carácter personal contenidos en la declaración de voluntad vital anticipada a los/las profesionales sanitarios/as implicados/as en mi proceso asistencial.</p> <p>Segundo.- La cesión de dichos datos al Registro Nacional de Instrucciones Previas.</p>

CÓDIGO IDENTIFICATIVO

Nº REGISTRO, FECHA Y HORA

DECLARACIÓN DE VOLUNTAD VITAL ANTICIPADA

Decreto / de de (BOJA nº de fecha)

Yo, D/Dª: con D.N.I./NIE PASAPORTE Nº:

NUHSA Nº

Fecha de Inscripción:

MANIFIESTO

Que mediante esta Declaración de Voluntad Vital Anticipada expreso los **valores y preferencias** que deben respetarse en la asistencia sanitaria que reciba **en el caso de que no pueda expresar personalmente mi voluntad.**

DECLARO

PRIMERO.- VALORES VITALES QUE SE HAN DE TENER EN CUENTA Y QUE SUSTENTAN MIS DECISIONES Y PREFERENCIAS

Deseo que las personas que tengan que tomar decisiones sanitarias en mi lugar cuando me encuentre en una situación clínica que me impida expresar personalmente mi voluntad, tengan en cuenta los siguientes valores:

SEGUNDO.- SITUACIONES CLÍNICAS EN LAS QUE QUIERO QUE SE APLIQUE ESTE DOCUMENTO

Este documento ha de tenerse en cuenta en aquellas situaciones clínicas en las que no haya expectativa de recuperación, que me produzcan un gran deterioro físico o mental o que sean incompatibles con las instrucciones y valores expresados en esta Declaración.

A continuación incluyo algunas situaciones clínicas concretas en las que deseo se aplique este documento.

A large empty rectangular box with a thin black border, intended for the user to list specific clinical situations where they want this document to be applied. The box is currently blank.

TERCERO.- INDICACIONES SOBRE LAS SIGUIENTES ACTUACIONES SANITARIAS

Teniendo en cuenta lo que expreso en los apartados primero y segundo de esta Declaración, mi voluntad sobre las siguientes actuaciones sanitarias, siempre que estén clínicamente indicadas, es:

- Transfusión de sangre

Deseo recibirlo No deseo recibirlo No me pronuncio

- Alimentación mediante nutrición parenteral (sueros nutritivos por vía venosa)

Deseo recibirlo No deseo recibirlo No me pronuncio

- Alimentación mediante tubo de gastrostomía (tubo que se coloca directamente en el estómago)

Deseo recibirlo No deseo recibirlo No me pronuncio

- Alimentación mediante sonda nasogástrica (tubo que se introduce por la nariz y llega hasta el estómago)

Deseo recibirlo No deseo recibirlo No me pronuncio

- Hidratación con sueros por vía venosa

Deseo recibirlo No deseo recibirlo No me pronuncio

- Técnicas de depuración extrarrenal

Deseo recibirlo No deseo recibirlo No me pronuncio

- Respirador artificial

Deseo recibirlo No deseo recibirlo No me pronuncio

- Reanimación cardiopulmonar

Deseo recibirlo No deseo recibirlo No me pronuncio

- Sedación paliativa

Deseo recibirlo No deseo recibirlo No me pronuncio

Otras actuaciones sanitarias sobre las que deseo expresar mis instrucciones, siempre que dichas actuaciones sanitarias estén clínicamente indicadas:

CUARTO.- DONACIÓN DE ÓRGANOS Y TEJIDOS

Acepto que me puedan aplicar los procedimientos para la certificación de la muerte y para mantener viables los órganos hasta su extracción. Mi voluntad en relación con la donación de órganos y tejidos de mi cuerpo es:

- Donar los órganos

Sí No No me pronuncio

- Donar los tejidos

Sí No No me pronuncio

Consideraciones respecto a la donación de órganos y tejidos:

QUINTO.- OTRAS CONSIDERACIONES Y PREFERENCIAS QUE DEBEN TENERSE EN CUENTA

Finalmente, deseo que en las decisiones sanitarias que me afecten se tenga en cuenta lo siguiente:

CÓDIGO IDENTIFICATIVO

ANVERSO (Hoja 3 de 3)

ANEXO II

SEXTO.- DESIGNACIÓN DE REPRESENTANTE/S:

Deseo nombra a
como persona que actúe como mi **representante** que vele para que se cumplan mis deseos en las situaciones clínicas incluidas en esta Declaración y decida, teniendo en cuenta mis valores vitales, en aquellas situaciones que no se contemplan en ella de forma explícita.

D/D*: con DNI/NIE PASAPORTE N°
nacido/a el día de de sexo H M , con domicilio en
Localidad Provincia Código Postal

Deseo, asimismo, para el caso en que mi representante no pueda comparecer por imposibilidad manifiesta, designar como **persona sustituta de mi representante**, con las mismas atribuciones y limitaciones, a :

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Localidad Provincia Código Postal

Además deseo expresar lo siguiente en relación a las funciones de mi representante y de la persona que le sustituya:

SEPTIMO.- LUGAR Y FECHA DE OTORGAMIENTO

En a ⁽¹⁾ de de

Firma y rúbrica ⁽²⁾

Fdo.:

(1) Consignar la fecha con letra

(2) El documento deberá ir firmado y rubricado en todas y cada una de sus hojas.

PROTECCIÓN DE DATOS

En cumplimiento de lo dispuesto en la Ley Orgánica 15/1999, de 13 de diciembre, de Protección de Datos de Carácter Personal, la Consejería de Salud le informa que los datos personales obtenidos mediante la cumplimentación de este documento/impreso/formulario y demás que se adjuntan van a ser incorporados, para su tratamiento, en un fichero de Registro de Voluntades Vitales Anticipadas de Andalucía. Asimismo, se le informa que la recogida y tratamiento de dichos datos tienen como finalidad permitir el ejercicio por la persona de su derecho a decidir sobre las actuaciones sanitarias de que pueda ser objeto en el supuesto de que llegado el momento no goce de capacidad para consentir por sí misma. De acuerdo con lo previsto en la citada Ley Orgánica, puede ejercitar los derechos de acceso, rectificación, cancelación y oposición dirigiendo un escrito ante las sedes habilitadas del Registro de Voluntades Vitales Anticipadas de Andalucía.

CÓDIGO IDENTIFICATIVO

Nº REGISTRO, FECHA Y HORA

ACEPTACIÓN DE LA PERSONA QUE ACTÚA COMO REPRESENTANTE

Decreto / de de (BOJA nº de fecha)

D/D^a: con DNI/NIE PASAPORTE Nº:
 nacido/a el día de de sexo H M , con domicilio en
 Localidad Provincia Código Postal
 País Teléfonos de contacto
 Correo electrónico

Acepto representar a:

D/D^a: con DNI/NIE PASAPORTE Nº:
 nacido/a el día de de sexo H M , con domicilio en
 Localidad Provincia Código Postal
 País Teléfonos de contacto
 Correo electrónico

Consiento que se consulten mis datos de identidad a través del sistema de verificación de identidad.

No consiento que se consulten mis datos de identidad a través del sistema de verificación de identidad y aporoto fotocopia autenticada del DNI /NIE

Asumo que mis funciones son:

- Buscar siempre el mayor beneficio y el respeto a la dignidad de la persona a la que represento.
- Velar para que, en las situaciones clínicas contempladas en la Declaración, se cumplan las instrucciones que la persona a la que represento haya dejado establecidas.
- Tener en cuenta los valores u opciones vitales recogidos en la Declaración de la persona a la que represento, para así presumir su voluntad en las situaciones clínicas no contempladas explícitamente en la Declaración de Voluntad Vital Anticipada.
- Respetar las indicaciones que la persona a la que represento haya establecido respecto al ejercicio de mi función de representante.

LUGAR Y FECHA

En a (1) de

Firma y rúbrica:
 (1) Consignar la fecha con letra

Fdo.:

PROTECCIÓN DE DATOS

En cumplimiento de lo dispuesto en la Ley Orgánica 15/1999, de 13 de diciembre, de Protección de Datos de Carácter Personal, la Consejería de Salud le informa que los datos personales obtenidos mediante la cumplimentación de este documento/impreso/formulario y demás que se adjuntan van a ser incorporados, para su tratamiento, en un fichero de Registro de Voluntades Vitales Anticipadas de Andalucía. Asimismo, se le informa que la recogida y tratamiento de dichos datos tienen como finalidad permitir el ejercicio por la persona de su derecho a decidir sobre las actuaciones sanitarias de que pueda ser objeto en el supuesto de que llegado el momento no goce de capacidad para consentir por sí misma. De acuerdo con lo previsto en la citada Ley Orgánica, puede ejercitar los derechos de acceso, rectificación, cancelación y oposición dirigiendo un escrito ante las sedes habilitadas del Registro de Voluntades Vitales Anticipadas de Andalucía.

CÓDIGO IDENTIFICATIVO

Nº REGISTRO, FECHA Y HORA

ACEPTACIÓN DE LA PERSONA SUSTITUTA DEL / DE LA REPRESENTANTE

Decreto / ,de de (BOJA nº de fecha)

D/Dº: con DNI/NIE PASAPORTE Nº:
 nacido/a el día de de sexo H M , con domicilio en
 Localidad Provincia Código Postal
 País Teléfonos de contacto
 Correo electrónico

Acepto sustituir a:

D/Dº: con DNI/NIE PASAPORTE Nº:
 nacido/a el día de de sexo H M , con domicilio en
 Localidad Provincia Código Postal
 País Teléfonos de contacto
 Correo electrónico

- Consiento que se consulten mis datos de identidad a través del sistema de verificación de identidad.
- No consiento que se consulten mis datos de identidad a través del sistema de verificación de identidad y aporoto fotocopia autenticada del DNI /NIE

Asumo que mis funciones son:

- Buscar siempre el mayor beneficio y el respeto a la dignidad de la persona a la que represento.
- Velar para que, en las situaciones clínicas contempladas en la Declaración, se cumplan las instrucciones que la persona a la que represento haya dejado establecidas.
- Tener en cuenta los valores u opciones vitales recogidos en la Declaración de la persona a la que represento, para así presumir su voluntad en las situaciones clínicas no contempladas explícitamente en la Declaración de Voluntad Vital Anticipada.
- Respetar las indicaciones que la persona a la que represento haya establecido respecto al ejercicio de mi función de representante.

LUGAR Y FECHA

En a (1) de de
 Firma y rúbrica:
 (1) Consignar la fecha con letra

Fdo.:

PROTECCIÓN DE DATOS
 En cumplimiento de lo dispuesto en la Ley Orgánica 15/1999, de 13 de diciembre, de Protección de Datos de Carácter Personal, la Consejería de Salud le informa que los datos personales obtenidos mediante la cumplimentación de este documento/impreso/formulario y demás que se adjuntan van a ser incorporados, para su tratamiento, en un fichero de Registro de Voluntades Vitales Anticipadas de Andalucía. Asimismo, se le informa que la recogida y tratamiento de dichos datos tienen como finalidad permitir el ejercicio por la persona de su derecho a decidir sobre las actuaciones sanitarias de que pueda ser objeto en el supuesto de que llegado el momento no goce de capacidad para consentir por sí misma. De acuerdo con lo previsto en la citada Ley Orgánica, puede ejercitar los derechos de acceso, rectificación, cancelación y oposición dirigiendo un escrito ante las sedes habilitadas del Registro de Voluntades Vitales Anticipadas de Andalucía.

