MINISTRY OF HEALTH
For a healthier life

Medical Administration
The Central Data Bank of Advance Medical Directives

Appendix 1

Advanced Directives as to Future Medical Care Of a Dying Patient

(Paragraph 31)

This form is to be filled and completed by persons wishing to give advance directives[1] as to their future medical care —

(1) requesting that medical procedures commonly performed in Israel not be performed on him/her (see Box A), or

(2) requesting that life-prolonging medical procedures be performed, even if unjustified in the given circumstances (see Box B)

I, the undersigned, _____, ID.No. _____, year of birth_____, address_____
being competent as defined by The Dying Patient Law, 2005 (hereafter — The Dying Patient Law), hereby issue, under the provisions of the Dying Patients Law, advance medical directives:

For the purpose of issuing advance medical directives I declare as follows:

(a) (1) My current medical state is:

☐ Generally healthy

☐ It has been determined that I am a Dying patient

(2) I have received medical information[2] from _____.
The said information is as follows: (to be completed by a specialist physician, physician or nurse, as the case may be)

_____
_____
_____

(b) I am aware that these directives shall come into effect, that is, that the medical care given me shall conform to these directives, only once it has been determined that I am Dying Patient, and I have been declared incompetent **and I am suffering significantly**, all the foregoing within the meaning of the Dying Patient law.

[1] Advance Medical Directives are issued by a competent person, and state his wishes as to his future medical care should he become terminally illa dying patient, and incompetent, or terminally ill (death imminent)a dying patient in final satge, and incompetent.

[2] Medical Information: (1) A specialist physician shall give a person confirmed to be terminally ill information about his medical condition, including medical information about his condition which is relevant to his issuing directives, and medical information he may reasonably require for issuing advance medical directives.

(2) A physician or nurse shall give a person not confirmed to be terminally ill medical information, which he may reasonably require for issuing advance medical directives.

(c) I am aware that if it has been determined that I am Dying, but have not been declared incompetent, that my expressed wishes shall take precedence over the provisions of these directives.

(d) I am aware that I may alter or cancel these medical directives at any time, as long as I have not been declared incompetent within the meaning of the law; the cancellation shall take the form of new medical directives or a completed cancellation form, as provided in Appendix 4.

(e) I am aware that these medical directives shall remain valid for five years or for a period not exceeding five years, namely until: _____ (A date maybe specified here not more than five years from the date the advance medical directives form is signed). After the end of the said period a Responsible Physician may (but not must) take these directives into account, unless they were cancelled by me.

Box A: ADVANCE MEDICAL DIRECTIVES <u>NOT</u> TO PERFORM LIFE-PROLONGING MEDICAL PROCEDURES			
A1.	(1)	I am aware that only if I reach a state of 'significant suffering', as defined by me below, and shall be a dying patient, and incompetent, will procedures not be performed on me in accordance with the advance medical directives in this document; significant suffering, as I define it, is—	
		(Check [in the box] whichever of the following (one or more) defines significant suffering for you):	
		☐ requiring to be artificially fed / nourished	
		☐ I am unconscious	
		☐ I am quadriplegic (paralyzed in all 4 limbs)	
		☐ a state of dementia	
		☐ I require any of the following treatments: _____ _____ _____	
		☐ I am in one of the following states / conditions– _____ _____ _____	
	(2)	I am aware that if I have not defined in Clause A1(1) above what I consider to be significant suffering, I shall be considered as being in a state of significantly suffering only if I am experiencing pain or suffering which a reasonable person would be ready to make a great effort to avoid or eliminate, even at the cost of significant injury to his	

		quality of life or life expectancy, and that only if I am in that state, and am also a dying aptient and incompetent, will these advance medical directives be followed.	
A2. Should I reach a dying patient state these are the procedures I wish not to be performed / to be performed on me:			
			[Cross out what does not apply]
	(a)	Resuscitation in any possible way	Do not perform/ Perform
	(b)	Resuscitation by external cardiac massage	Do not perform/ Perform
	(c)	Resuscitation by endotracheal intubation	Do not perform/ Perform
	(d)	Resuscitation by administering resuscitation drugs	Do not perform/ Perform
	(e)	Resuscitation by electric shock	Do not perform/ Perform
	(f)	Connection to a ventilator with a timer (Temporary artificial breathing machine)	Do not perform/ Perform
		If this procedure is to be performed, please specify for how long it is to be maintained: _____ days/weeks/months/without time limit (Cross out what does not apply)	
	(g)	Dialysis	Do not perform/ Perform
		If this procedure is to be performed, should it be halted if the dialysis is proving to have no useful effect?	Do not perform/ Perform
	(h)	Major surgery (e.g. amputating a necrotic limb, removing a necrotic internal organ)	Do not perform/ Perform
	(i)	Minor surgery (e.g. amputating a necrotic finger)	Do not perform/ Perform
	(j)	Radiotherapy for malignant diseases	Do not perform/ Perform
	(k)	Chemotherapy for malignant diseases	Do not perform/ Perform
	(l)	Antibiotic treatment for severe septicemia resistant to regular antibiotic treatment	Do not perform/ Perform
	(m)	Diagnostic tests (blood, X-rays, cardiac monitor)	Do not perform/ Perform
A3. Should I be a dying patient in Final Stage, these are the procedures I wish <u>not</u> to be performed / to be performed on me:**			
			[Cross out what does not apply]
	(a)	Resuscitation in any possible way	Do not perform/ Perform
	(b)	Resuscitation by external cardiac massage	Do not perform/ Perform

	(c)	Resuscitation by endotracheal intubation	Do not perform/ Perform
	(d)	Resuscitation by administering resuscitation drugs	Do not perform/ Perform
	(e)	Resuscitation by electric shock	Do not perform/ Perform
	(f)	Connection to a ventilator with a timer (Temporary artificial breathing machine)	Do not perform/ Perform
		If this procedure is to be performed, please specify for how long it is to be maintained: _____ days/weeks/months/without time limit (Cross out what does not apply)	
	(g)	Dialysis	Do not perform/ Perform
		If this procedure is to be performed, should it be halted if the dialysis is proving to have no useful effect?	Do not perform/ Perform
	(h)	Major surgery (e.g. amputating a necrotic limb, removing a necrotic internal organ)	Do not perform/ Perform
	(i)	Minor surgery (e.g. amputating a necrotic finger)	Do not perform/ Perform
	(j)	Radiotherapy for malignant diseases	Do not perform/ Perform
	(k)	Chemotherapy for malignant diseases	Do not perform/ Perform
	(l)	Antibiotic treatment for severe septicemia resistant to regular antibiotic treatment	Do not perform/ Perform
	(m)	Diagnostic tests (blood, X-rays, cardiac monitor)	Do not perform/ Perform
	(n)	Routine procedures, e.g. giving antibiotics, blood & blood products	Do not perform/ Perform
	(o)	Treating intercurent illnesses, e.g. administering insulin	Do not perform/ Perform
	(p)	Giving food and liquids artificially	Do not perform/ Perform
	(q)	Giving palliative treatment and drugs	Do not perform/ Perform

** With regard to the subsidiary procedures specified in clauses (n) – (q) above, the Dying Patient Act, 2005, states that directions that they not be performed can apply in the case of an incompetent Dying Patient in Final Stage, only if he is suffering significantly.

A4. Instructions for other Emergency Situations***:**

[Complete section A4 only if you have directives for an emergency situation other than the ones mentioned above.]

_____

_____

_____

A5. Personal Directions not mentioned above			
	_____ _____ _____		
B. ADVANCE MEDICAL DIRECTIVES THAT EXCEPTIONAL MEDICAL PROCEDURES BE PERFORMED, EVEN WHEN THE ATTENDING PHYSICIANS CONSIDER THEM UNJUSTIFIED IN THE GIVEN CIRCUMSTANCES			
B1.	Every possible medical procedure that can prolong my life, is to be preformed, even if the said procedures will cause me additional suffering and even if my attending physicians consider the procedures unjustifiable. It is my firm request that my physicians: perform full resuscitation, endotracheal intubation, connect me to a ventilator (artificial breathing machine), perform dialysis, chemotherapy, radiotherapy, administer antibiotics, blood and blood products, food and liquids, in any manner possible and as part of any medical procedure capable of prolonging my life.		
	▪	These directives shall apply when I am - (Either or both boxes may be checked)	□ A dying patient (up to 6 months life expectancy)
			□ A Dying Patient in Final Stage (up to 2 weeks life expectancy)
	▪	These directives include / do not include experimental procedures. (Cross out what does not apply)	
B2.	**Instructions for other Emergency Situations**: [Complete this section only if you have directions for an emergency situation other than the ones enumerated above.]		
	_____ _____ _____		
B3.	**Personal directions not mentioned above**:		
	_____ _____ _____		
C.	(1)	In addition to these advance medical directives I have given a Surrogacy Appointment, and I direct my attending physicians to act in accordance with both the said Surrogacy Appointment and these medical directives	☐ Check this box if Surrogacy Appointment was given
	(2)	I hereby direct that, in case of a contradiction between my advance medical directive and a directive of my appointed surrogate, precedence shall go to -	
		☐ My advance medical directives	☐ My appointed Surrogate

	(3)	I am aware that, in the absence of directions under Article C2 above, concerning a contradiction between these advance medical directives and the said surrogacy appointment, the directives shall take precedence. However - if the surrogacy appointment shall have been given a considerable time after the directives, then an institutional Committee shall decide the precedence between them.
	4.	Further instructions concerning a contradiction between an advance medical directive and a directive my appointed Surrogate:
		_____ _____ _____

*** Emergency situation — a situation in which immediate treatment must be given if the patient is not to die.

DECLARATION AND SIGNATURE

Informing other persons of advance medical directives:
[There is no duty to inform other persons, but doing so increases the chances that your directives will be effectively and correctly observed. (If you have not informed another person go directly to the next section - Signature)

I hereby declare that I have talked with the persons noted below about this document and that **I have given them/ have not given them** (Cross out whichever does not apply) a copy of this document:

For each box checked, give name, address and telephone number of the person/persons informed.

☐ Spouse/ life partner _____
_____
Tel:_____

☐ Other Relative _____
_____
Tel:_____

☐ A Doctor _____
_____
Tel:_____

☐ Attorney / Lawyer _____
_____
Tel:_____

☐ Rabbi/priest/ Kadi _____
_____
Tel:_____

☐ Other person _____
_____
Tel:_____

Signature of Person Issuing these Advance Medical Directives
(<u>The signatory must sign in the presence of 2 witnesses</u>)

I sign this document after deap and careful consideration and of my own free and autonomous will, and not in consequence of any familial, social or other pressure.

Signature: _____ Tel. no. (landline): _____
Tel. no. (mobile):_____ Date: _____

[Should the issuer of these directives not speak or read Hebrew, please attach a written authorization of the person who translated for him/her the explanations and directives in the document.]

<u>Signature of Witnesses</u>
(<u>The 2 witnesses must sign in each other's presence</u>)

We, the undersigned, witness that the above signatory of this document —

☐ Is personally known to us

☐ Identified himself/herself to us by means of an identifying document which included a photo of the signatory
[Check one of the two above boxes]

- Signed this document in our presence and that he/she appears to us fully aware and speaking to the point, and that there is no sign of any pressure brought to bear on him/her.
- <u>Further</u>: I declare that I do not hold the signatory's surrogacy appointment, nor am I a candidate to do so, nor do I have any economic or other interests involving the signatory.
  (A witness may not be one that has economic or other interests involving the signatory, including a family member who has economic or other such interests` However, a doctor or a nurse may be witnesses)

Witness: Name: _____ Id. no. _____
Address:_____
Tel. no. (landline): _____Tel. no. (mobile):_____
Signature: _____ Date: _____

Witness: Name: _____ Id. no. _____
Address:_____
Tel. no. (landline): _____Tel. no. (mobile):_____
Signature: _____ Date: _____

Signature of Person who Gave the Signatory Medical Information

(1) **To be completed if it has been determined that the issuer of these directives is a Dying Patient:**

I, _____, a specialist physician, hereby confirm that I wrote the précis of medical information and on (date) _____ gave Mr./ Ms. _____ an explanation of his/her medical condition, including medical information about his/her condition which is relevant to his/her issuing directives and also medical information he/she may reasonably require for issuing advance medical directives. I also confirm that I explained to him/her the medical terms used in this form and that it was my impression that he/she understood the information I gave him/her.

Name: _____ Id. no. _____
Address:_____
Tel. no. (landline): _____Tel. no. (mobile):_____
Signature: _____ Date: _____

(2) **To be completed if it has <u>not</u> been determined that the issuer of these directives is a Dying patient:**

I, _____, a physician/ registered nurse, [Cross out whichever does not apply], hereby confirm that I wrote the précis of medical information and on (date) _____ gave Mr./ Ms. _____ medical information about his/her condition he/she may reasonably require for issuing advance medical directives. I also confirm that I explained to him/her the medical terms used in this form and that it was my impression that he/she understood that information I gave him/her.

Name: _____ Id. no. _____
Address:_____
Tel. no. (landline): _____Tel. no. (mobile):_____
Signature: _____ Date: _____

The Central Data Bank of Advance Medical Directives
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39 Yirmiyahu St., Jerusalem 9446724
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1st Supplement- Advance Medical Directives

Before you send…

To avoid common mistakes while filling out Advance Medical Directives form, and to save unnecessary correspondence to correct the deficiencies, please check all of the following *before sending the form.*

☐ P. 1	- You must specify your current residential address in accordance with your registration at the Population Registry. If you wish you may also specify additional mailing address.
☐ P. 2	The person providing medical explanation (a physician or a registered nurse) must WRITE that they explained the medical terms in pp. 4 and 5 detailing several examples, and that they made sure you understood their explanation. This is NOT the place to detail your medical diagnoses. (Only in case that you are a dying patient, a medical specialist should write your medical diagnosis, in addition to explaining the medical terms as stated above).
☐ P. 3	You must specify name of the agent holding the Power of Attorney and his or her ID card No. It is recommended to add their phone No.
☐ Pp.4-5	Mark what treatments you wish to avoid or not to avoid. Make sure you do not skip any of the treatments (sections). Also, in regard of section 18 in p. 5, this is a palliative care and not a life-prolonging treatment. If you mark that you wish to avoid it, we will have to make sure this is really what you want before we confirm the form, as it does not conform to the spirit of the law.
☐ P. 4	Choose only one of the following options: A, B, or C. If you chose option A, do not fill in the tables in pp. 5 and 6. Only if you chose option C you have fill in the tables on pp. 5 and 6 and mark in each of the items whether you would you like to receive life-prolonging medical care or to avoid receiving such medical care.
☐ P. 7	If you fill the tables in pp. 4 and 5, do not fill page 7. Page 7 should be filled only by those who wish to receive extraordinary life-prolonging medical care.
☐ P. 8 ☐ P. 8	If you are also filling Power of Attorney: - You must mark it (part C section 1) and send us Power of Attorney form. You must mark which provision should prevail in case of a conflict between a medical directive and the power of attorney (part C section 2). - You must sign and date at the bottom of the page. The date of your signature MUST be the same as the date of the witnesses' signatures in page 9. It is recommended to add a phone No. for clarifications if needed.

☐ P. 9	- At the top of the page there are two empty boxes (□) in which the witnesses MUST indicate how they know you. - The form MUST be signed by two witnesses, who are **NOT** first-degree relatives. The witnesses and you must sign on at the same time and in the same place, therefor the date of your signature in p. 8 MUST be the same as the date of the witnesses' signature. - "Signature of the person providing medical information" - the physician or the registered nurse must fill in all required information and sign.
☐	Please attach a clear copy of your ID card including appendix.
☐	Please send the form by **registered mail** to the following address: Ministry of Health The Central Data Bank of Advance Medical Directives Yirmiyahu St. 39, Jerusalem 9446724

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