Waiver of Right to Request or Object to Treatment

Part 6 is a special part that may be used by people who want their future responses to offered health treatment disregarded or ignored. **You must have an agent to fill out this Part.**

There may be situations in which you might be objecting to or requesting treatment but would then want your objections or requests *to be disregarded.* If you have had treatment in the past that scares you or is uncomfortable or painful you may be likely to say "no" when it is offered in a future health crisis. Still, you may know that this is the only way for you to come through a bad time or even survive. You understand that it is necessary and you would want it again if you had to have it. This Part will help you let your agent, and others know what you *really* want for yourself.

Because this is signing away a basic right that all patients have (to refuse or to request treatment) unless a court orders otherwise, you will need to give this much careful thought. You will also have to have additional signatures and assurances at the time you fill out this Part of your Advance Directive.

If you think Part 6 could apply to you and be helpful in your situation, you need to be sure that everyone involved in your care understands that you are making this choice of your own free will and that you understand the ramifications of waiving your right either to consent or to object to treatment.

Unlike other Parts of your Advance Directive, you can revoke Part 6 ***only when you have capacity to make medical decisions*** as determined by your doctor and another clinician.

For your agent to be able to make healthcare decisions over your objection, you must:

- Name your agent who is entitled to make decisions over your objection;
- Specify what treatments you are allowing your agent to consent to or to refuse over your objection;
- State that you either do or do not desire the specified treatment even over your objection at the time and, further, specify your wishes related to voluntary and involuntary treatment and release from that treatment or facility;
- Acknowledge in writing that you are knowingly and voluntarily waiving the right to refuse or receive specified treatment at a time of incapacity;
- Have your agent agree in writing to accept the responsibility to act over your objection;
- Have your clinician affirm in writing that you appeared to understand the benefits, risks, and alternatives to the proposed health care being authorized or rejected by you in this provision; and
- Have an **ombudsman, recognized member of the clergy, attorney licensed to practice in Vermont, or a probate court designee** affirm in writing that he or she has explained the nature and effect of this provision to you and that you appeared to understand this explanation and be free from duress or undue influence.

NAME _____ DOB _____ DATE _____

PART 6: WAIVER OF RIGHT TO REQUEST OR OBJECT TO FUTURE TREATMENT

I hereby give my agent _____ the authority to consent to or refuse the following treatment(s) over my objection if I am determined by two clinicians to lack capacity to make healthcare decisions at the time such treatment is considered:

1. **I *do* want** the following treatment to be provided, even over my objection, at the time the treatment is offered: _____

   I do *not* want the following treatment, even over my request for that treatment, at the time the treatment is offered: _____

2. I give permission for my agent to agree to have me admitted to a designated hospital or treatment facility even over my objection.

   _____ Yes _____ No

3. I give my agent permission to agree that my release from a voluntary admission for mental health treatment may be delayed even over my objection for up to four days so that a decision can be made regarding whether I meet criteria to be involuntarily committed.

   _____ Yes _____ No

4. I hereby affirm that I am knowingly and voluntarily waiving the right to refuse or request specified treatment at a time of incapacity, and that I understand that my doctor and one other clinician will determine whether or not I have capacity to make health care decisions at that time. I know that I can revoke this part of my Advance Directive only when I have the capacity to do so, as determined by my doctor and at least one other clinician.

Signed: _____ , Principal Date: _____

Acknowledgements

Acknowledgement by Agent — I hereby accept the responsibility of consenting to or refusing the treatments specified above, even if to do so would be against the principal's expressed wishes at the time treatment is considered.

Signed: *(Agent)*_____ and *(Alternate)*_____

Print names: _____ _____

Phone: _____ _____

Date: _____ _____

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Acknowledgement of principal's clinician — I affirm that the principal appears to understand the benefits, risks, and alternatives to the health care specified above that is being consented to or refused by the principal.

Signed: _____ Title: _____

Facility: _____ Date: _____

Please print name: _____

Acknowledgement by persons who explain Part 6 — I, as the designated person to explain Part 6, affirm that I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in Vermont, or a probate court designee and that I have:

- Explained the nature and effect of this Waiver of the Right to Request or Object to Treatment to the principal, and
- The principal appears both to understand the nature and effect of this provision and to be free from duress or undue influence.
- If the principal is in a hospital at the time of signing, that I am not affiliated with that hospital, and
- I am not related to the principal, a reciprocal beneficiary, or the principal's clergy or a person who has exhibited special care and concern for the principal.

Signed: _____

Position: _____ Date: _____