Would your doctor or family know where to find your Advance Health Care Directive or Living Will quickly if you were unable to tell them where it is?

An Advance Health Care Directive, which includes a Living Will, is only useful if it can be found and read when you are unable to make medical decisions for yourself. Typically, if you are unable to make medical decisions for yourself, you are not able to tell your doctor or your family where your Advance Directive is located. This is why the Attorney General's Office has developed a small card that you can keep in your wallet to document the location of your Advance Health Care Directive.

Two cards are provided. Just cut out a card, fill it in, fold it, and put it in your wallet or billfold.

These cards are not the same as a Do Not Resuscitate or DNR order.

If you want emergency medical services personnel to refrain from resuscitating you, you need a Maryland Medical Orders for Life-Sustaining Treatment (MOLST) form. That form has to be filled out by a physician or a nurse practitioner. Copies are available from the Maryland Institute for Emergency Medical Services Systems by calling 410-706-4367. You can also visit the website at www.marylandmolst.org and click on "MOLST Form."

For more information about Advance Health Care Directives, please visit the Attorney Gener-al's website at www.marylandattorneygeneral.gov and click on the button labeled Advance Directive/Liv-ing wills. You will find advance directive forms and instructions and other useful information, including the booklet: "Making Medical Decisions for Someone Else: A Guide for Marylanders" by clicking on "Guidance for Health Care Proxies." Copies of advance directive forms and instructions and the booklet can also be obtained by calling 410-576-7000.

ADVANCE HEALTH CARE DIRECTIVE

I HAVE AN ADVANCE DIRECTIVE.

My Name: _____

My Physician's Name: _____

Physician's Phone #: _____

COPIES ARE HELD BY:

Name: _____

Phone #s: _____

_____

(over)

fold

OTHER COPIES ARE HELD BY:

Name: _____

Phone #s: _____

Name: _____

Phone #s: _____

I ALSO HAVE A HEALTH CARE AGENT.

Agent's Name: _____

Phone #s: _____

(over)

ADVANCE HEALTH CARE DIRECTIVE

I HAVE AN ADVANCE DIRECTIVE.

My Name: _____

My Physician's Name: _____

Physician's Phone #: _____

COPIES ARE HELD BY:

Name: _____

Phone #s: _____

_____

(over)

fold

OTHER COPIES ARE HELD BY:

Name: _____

Phone #s: _____

Name: _____

Phone #s: _____

I ALSO HAVE A HEALTH CARE AGENT.

Agent's Name: _____

Phone #s: _____

(over)