Patient's Name: _____ **Pt. #:** _____ **Date:** _____

Health Care Treatment Directive (Living Will)

I, _____ being of sound mind, willfully and voluntarily make this Health Care Treatment Directive to exercise my right to determine the course of my health care and to provide clear and convincing proof of my treatment decisions **when I lack the capacity to make or communicate my decisions.**

If my physician believes that a certain life-prolonging procedure or other health care treatment may provide me with comfort, relieve pain or lead to a significant recovery, I direct my physician to try the treatment for a reasonable period of time. However, if such treatment proves to be ineffective, I direct the treatment to be withdrawn, even if so doing might shorten my life. My dying shall not be artificially prolonged under the conditions outlined below.

I direct I be given health care treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

If there is a statement in paragraph 1 or 2 below with which you do not agree, draw a line through it and add your initials.

1) I direct all life prolonging procedures to be withheld or withdrawn when a situation exists in which there is no realistic hope of significant recovery and in which two physicians have determined that my death will occur without life-supporting measures, and I have:
   - a terminal condition: or
   - a condition, disease or injury in which there is no hope of a significant recovery and there is no reasonable expectation that I will regain an acceptable quality of life; and where life-supporting equipment will but prolong the dying process; or
   - substantial brain damage or brain disease which cannot be significantly reversed; or
   - other:_____

2) When the above conditions exist, life-prolonging procedures I choose to have withheld or withdrawn include (assume that any item crossed out would be administered to you):
   - surgery
   - heart-lung resuscitation(CPR)
   - antibiotics
   - dialysis
   - mechanical ventilator(respirator)
   - tube feedings (food and water delivered through a tube in the vein, nose or stomach)
   - other:_____

3) I make other instructions as follows (you may describe what a minimally acceptable quality of life is for you):

_____

_____

_____

If you do not wish to name an agent to make health care decisions for you, initial here:_____, go to the end of the document, sign and have witnessed.

HEALTH CARE TREATMENT DIRECTIVE AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

Patient's Name: _____ **Pt. #:** _____ **Date:** _____

Durable Power of Attorney for Health Care Decisions

General Statement: I hereby execute the following Durable Power of Attorney for Health Care Decisions to be effective WHEN AND ONLY WHEN my physician and agent agree that I lack capacity to make or communicate my health care decisions and my above Health Care Treatment Directive does not adequately cover the circumstances. This is a Durable Power of Attorney for Health Care Decisions, and the authority to interpret my desires is intended to be as broad as possible, and any expenses incurred should be paid by my resources. My agent may not delegate the authority to make decisions. My agent is authorized, as follows, to:

If there is a statement in paragraphs A through F with which you do not agree, draw a line through it and add your initials.

A. Consent, refuse or withdraw consent to any care, treatment, service or procedure (including tube feeding of food and water) used to maintain, diagnose or treat a physical or mental condition.
B. Have the same access to health care records and information that I could have, including the right to disclose the contents to others and to discuss the treatment decisions with them.
C. Make all necessary arrangements for health care, including admission/discharge, for any health care service, and to hire and fire medical personnel responsible for my care.
D. Move me into or out of any state for the purpose of complying with my Health Care Treatment Directive or the decisions of my agent.
E. Take any legal action reasonably necessary to do what I have directed.
F. Make decisions regarding organ donation, autopsy and the disposition of my body.

I appoint the following person to be my agent to make health care decisions for me WHEN AND ONLY WHEN I lack the capacity to make or communicate a choice regarding a particular health care decision and my Health Care Treatment Directive does not adequately cover the circumstances. I request that the person serving as my agent be my guardian if one is needed (if you do not wish to name an agent, write "NONE" in the space provided below).

AGENT:Name:_____

Address:_____

Only an agent named by me may act under this document. If any agent named by me is not available or not willing to make health care decisions for me or if an agent named by me is my spouse and is legally separated or divorced from me, I appoint the person or persons named below (in order named, if more than one is listed) as my agent (it is not necessary to name an alternate agent):

1ST ALTERNATE AGENT	2ND ALTERNATE AGENT
Name:_____	Name:_____
Address:_____	Address:_____
Telephone:_____	Telephone:_____

Protection of Persons Who Rely on My Agent: I and my estate hold my agent and my caregivers harmless and protect them against any claim for following this directive.

HEALTH CARE TREATMENT DIRECTIVE AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

Patient's Name: _____ **Pt. #:** _____ **Date:** _____

Severability: If any part of this document is held to be unenforceable under law, I direct that all of the other provisions of this document shall remain in force and effect.

I have executed this document on this day of_____,_____.

Signature:_____

Witnesses:_____

The person executing this document is personally known to me, is 18 years of age or older, of sound mind and voluntarily signed this document in my presence. I am 18 years of age or older and not related to the signer by blood, marriage or adoption; am not entitled (to my knowledge) to any portion of the estate of the signer; and am not directly financially responsible for the signer's medical care.

WITNESS: WITNESS:

Name:_____ Name:_____

Address:_____ Address:_____

Notarization is required in some states (e.g., in Missouri but not in Kansas) to enact a Durable Power of Attorney for Health Care and is recommended for anyone enacting this document.

Notarization

State of_____County of_____

On this _____day of _____, _____, before me personally appeared the aforesaid declarant to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of _____, State of _____, on the day and year first above written.

_____ _____

My Commission Expires Notary Public

Acceptance (optional):

I have discussed this document with the person making this directive, and I accept the responsibility designated to me as stated above.

_____ _____

First Agent Date

Discuss this document and your ideas about quality of life with your agent, physician(s), family members, friends and clergy, and provide them with a signed copy (or photocopy thereof) *You may revoke or change this document. Periodic review is recommended. If there are no changes after each review, initial and date in the margin.*

HEALTH CARE TREATMENT DIRECTIVE AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

HERE'S HOW IT WORKS

1. A representative of the facility will talk to you about your rights regarding refusal of medical and/or surgical interventions and your right to make advance directives. You also have the right not to make advance directives. That is your choice.
2. You may choose between a durable power of attorney for health care and a living will, or you may have both. The basic difference between the two is that the durable power of attorney for health care designates a particular person to make decisions for you when you are not able to decide for yourself and can cover all health care decisions. A living will states your wishes about withholding or withdrawing life-sustaining care.
3. If you choose to make advance directives, the facility may provide the necessary forms for making a living will or assigning a durable power of attorney for health care. If the facility does not provide the forms, this brochure lists a source for obtaining them. You do not need a lawyer in order to make an advance directive. However, legal advice is certainly appropriate. There are options other than the forms provided in state statutes that are legal and can be used.
4. A living will must be witnessed by two adult people. A durable power of attorney for health care may be witnessed or notarized. Although it is not necessary for the forms to be legal, it is recommended that the documents be both witnessed and notarized. This is in case you travel to another state that might require advance directives to be notarized.
5. If you make advance directives, you should discuss them with your physician. You are responsible for making copies available to him/her and all other doctors you deal with. You should also discuss and share copies of your advance directives with your family members. It is always a good idea to keep copies yourself.
6. If you wish to change your mind about your advance directives at a later date, you may do so. You can revoke the old document(s) and make new advance directives that must also be witnessed and/or notarized. A Living Will may be revoked by destroying the document, signing a written revocation or by telling an adult that the document no longer expresses your wishes. For a verbal revocation to be effective, the adult who heard the verbal revocation must confirm it in writing. This document must be given to the attending physician. A durable power of attorney for health care must be formally revoked in writing with a witnessed or notarized statement.

THE PATIENT SELF-DETERMINATION ACT

The Patient Self-Determination Act is a federal law that requires hospitals/facilities to "provide written information" to adult patients concerning "an individual's right under state law ... to make decisions concerning ... medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives." This brochure outlines what advance directives are and what some state statutes require.

ADVANCE DIRECTIVES

Advance directives are documents that state a patient's choices about treatment, including decisions like refusing treatment, being placed on life support, and stopping treatment at a point the patient chooses. It also includes requesting life-sustaining treatment, if that is wanted.

There are several kinds of advance directives. There are two that are mentioned most often. One is called a living will and the other is called a durable power of attorney for health care. Through advance directives, patients can make legally valid decisions about their medical treatment.

HEALTH CARE TREATMENT DIRECTIVE AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

STATE STATUTES

Statutes of some states recognize both a living will and a durable power of attorney for health care.

THE LIVING WILL

The living will allows any adult to sign a form (relating to themselves only) which states that life-sustaining procedures should be withheld or withdrawn when decision-making capacity is lost and when such procedures would merely prolong dying. Medical procedures deemed necessary to provide comfort or alleviate pain are not considered "life-sustaining procedures."

For the living will to be effective, two physicians must personally examine the patient and determine that the patient has a terminal illness. The physicians must agree that death will occur whether or not the medical procedure is done. The form is not effective if the patient is pregnant.

The living will must be witnessed by two adults who are not related to and will not inherit from the person making the living will.

THE DURABLE POWER OF ATTORNEY FOR HEALTH CARE

A durable power of attorney for health care is a document in which a person gives someone else the right to make decisions about health care for him/her. The person who would make the decisions is known as an "agent" and can be any adult except a physician or other health care provider (including people who work, own or are directors for hospitals and other health care institutions) unless the health care provider is related by blood or marriage to the person signing the document.

The powers which can be granted include: the power to make decisions, give consent, refuse consent or withdraw consent for organ donation, autopsy or the treatment of any physical or mental condition. The agent may also make all necessary arrangements for hospitalization, physicians or other care, and to request and receive all information and records, and to sign releases for records.

The person signing the durable power of attorney for health care can choose which of the above powers the agent will have. Specific instructions can be given. For example, a specific treatment may be prohibited. Requests for treatment, including life-sustaining care, can also be included. The special instructions allow the durable power of attorney for health care to be specific for each individual's needs.

The agent and the health care providers must follow the patient's expressed wishes. This means they must also respect any wishes that are stated in a living will. Unless limited, the durable power of attorney for health care allows the agent to make decisions about withholding or withdrawing life-sustaining treatment in all types of illnesses (including comas or persistent vegetative states) and is not limited to terminal illness.

To be effective, the document must be notarized or witnessed by two adults who are not related to and who will not inherit from the person signing the document.