// Prime Healthcare Providers
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This packet contains **three** (3) documents, which are very powerful ways to make your wishes about your health care known to your Primary Care Physician and other health care providers. They are:

1. **Durable Power of Attorney for Health Care**
2. **Directive to Physicians, commonly referred to as the living will**
3. **Consent to a "Do Not Resuscitate" Order**

l. The **Durable Power of Attorney for Health Care** is a document that allows you to *designate full power to an individual that you have chosen to make all medical decisions for you if you are not able to make those decisions for yourself*. If you execute the Power of Attorney, the person you designate can take over your decisions when you become incapable. **It is not necessary to wait until you are terminally ill**. The person named in your Power of Attorney can make any health decision that you would normally make yourself, including consent for treatment or refusal of treatment. *This means you have power to avoid having unwanted medical treatment or futile heroic measures*. If you sign this document, please be sure to make your wishes clearly known to the person you choose as your Durable Power of Attorney.

2. The **Directive to Physicians**, commonly referred to as the living will, gives health care professionals caring for you, information about your wishes for health care if you become terminally ill. In order to be classified as terminally ill, two physicians must certify your illness or injury as terminal. This document is **only valid if you are classified as terminally ill**. Signing this document allows you to *indicate whether or not you want to be kept alive by artificial means if there is little or no hope of recovery and the application of life-sustaining procedures would only serve to artificially postpone your death*. Included also in this document is an optional section which allows you to indicate whether or not you would choose to be *maintained with tube feedings or IV fluids in the event you were either to weak to swallow water or food or you became comatose*. Again, you would need to be classified as terminally ill in order for this section to apply.

3. The **Consent to A "Do Not Resuscitate" Order Document** is a document that indicates that in the event you suffer a cardiac or respiratory arrest, *you do not wish cardiopulmonary resuscitative (CPR) measures to be performed. CPR includes such measures as chest compressions and mechanical breathing.* Other methods used to maintain life, health or comfort such as pain medications, IV antibiotics and other appropriate medications will not necessarily be withheld if you sign this document.

Please read these documents very carefully. You are not required to sign any of these documents. They are optional and are meant solely to clarify *your wishes* to health care personnel. You may sign one, two or all three of these documents. If you decide to sign any of these documents, please make several copies. One copy should be given to your Primary Care Physician and another to your family. If you are hospitalized, you should take a copy of the signed documents with you so that it can be placed in your medical record. These documents can be canceled at any time you wish. If you make any changes to your documents, the one with the most recent date is the only one that would be valid. **Please be aware that if you call 911 for assistance, the emergency rescue personnel will not honor these documents. The assumption is that if you notify 911, you are requesting medical assistance. This means that any or all means will be used to preserve your life.**

If you have any questions, please do not hesitate to ask your doctor.

INFORMATION CONCERNING THE DURABLE POWER OF ATTORNEY FOR HEALTHCARE

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS.

Except to the extent you state otherwise, this document gives the person you name as your agent the authority to make any and all health care decisions for you in accordance with your wishes, including your religious and moral beliefs, when you are no longer capable of making them yourself. Because "health care" means any treatment, service, or procedure to maintain, diagnose, or treat your physical or mental condition, your agent has the power to make a broad range of health care decisions for you. Your agent may consent, refuse to consent, or withdraw consent to medical treatment and may make decisions about withdrawing or withholding life-sustaining treatment. Your agent may not consent to voluntary inpatient mental health services, convulsive treatment, psychosurgery or abortion. A physician must comply with your agent's instructions or allow you to be transferred to another physician.

Your agent's authority begins when your doctor certifies that you lack the capacity to make health care decisions.

Your agent is obligated to follow your instructions when making decisions on your behalf. Unless you state otherwise, your agent has the same authority to make decisions about your health care as you would have had.

It is important that you discuss this document with your physician or other health care provider before you sign it to make sure that you understand the nature and range of decisions that may be made on your behalf. If you do not have a physician, you should talk with someone else who is knowledgeable about these issues and can answer your questions. You do not need a lawyer's assistance to complete this document, but if there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

The person you appoint as agent should be someone you know and trust. The person must be 18 years of age or older or a person under 18 years of age who has had the disabilities of minority removed. If you appoint your health or residential care provider (e.g., your physician or an employee of a home health agency, hospital, nursing home, or residential care home, other than a relative), that person has to choose between acting as your agent or as your health or residential care provider; the law does not permit a person to do both at the same time.

You should inform the person you appoint that you want the person to be your health care agent. You should discuss this document with your agent and your physician and give each a signed copy. You should indicate on the document itself the people and institutions who have signed copies. Your agent is not liable for health care decisions made in good faith on your behalf.

Even after you have signed this document, you have the right to make health care decisions for yourself as long as you are able to do so and treatment cannot be given to you or stopped over your objection. You have the right to revoke the authority granted to your agent by informing your agent or your health or residential care provider orally or in writing, or by your execution of a subsequent durable power of attorney for health care. Unless you state otherwise, your appointment of a spouse dissolves on divorce.

This document may not be changed or modified. If you want to make changes in the document, you must make an entirely new one.

You may wish to designate an alternate agent in the event that your agent is unwilling, unable, or ineligible to act as your agent. Any alternate agent you designate has the same authority to make health care decisions for you.

THIS POWER OF ATTORNEY IS NOT VALID UNLESS IT IS SIGNED IN THE PRESENCE OF TWO OR MORE QUALIFIED WITNESSES. THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

(1) the person you have designated as your agent

(2) your health or residential care provider or an employee of your health or residential care provider;

(3) your spouse;

(4) your lawful heirs or beneficiaries named in your will or a deed; or

(5) creditors or persons who have a claim against you.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
DESIGNATION OF HEALTH CARE AGENT

I,____, appoint
Name:____
Address:____
____
____
Phone: ____

as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this document. The durable power of attorney for health care takes effect if I become unable to make my own health decisions and this fact is certified in writing by my physician.

LIMITATIONS ON THE DECISION MAKING AUTHORITY OF MY AGENT ARE AS FOLLOWS:

____
____
____

DESIGNATION OF ALTERNATE AGENT

(You are not required to designate an alternate agent but you may do so. An alternate agent may make the same health care decisions as the designated agent if the designated agent is unable or unwilling to act as your agent. If the agent designated is your spouse, the designation is automatically revoked by law if your marriage is dissolved.)

If the person designated as my agent is unable or unwilling to make health care decisions for me, I designate the following persons to serve as my agent to make health care decisions for me as authorized by this document, who serve in the following order:

A. First Alternate Agent
Name:____
Address:____
Phone:____

B. Second Alternate Agent
Name:____
Address:____
Phone:____

The original of this document is kept at_____________________________

The following individuals or institutions have signed copies:

Name:_____________________________________

Address:___________________________________

Name:______________________________________

Address:____________________________________

DURATION.

I understand that this power of attorney exists indefinitely from the date I execute this document unless I establish a shorter time or revoke the power of attorney. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my agent continues to exist until the time I become able to make health care decisions for myself.

(IF APPLICABLE) This power of attorney ends on the following date:_____________.

PRIOR DESIGNATIONS REVOKED.

I revoke any prior durable power of attorney for health care.

ACKNOWLEDGMENT OF DISCLOSURE STATEMENT

I have been provided with a disclosure statement explaining the effect of this document. I have read and understand that information contained in the disclosure statement.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)

I sign my name to this durable power of attorney for health care on the ______day of ______________, 19____at ___________________________________.
(City and State)

____
(Signature)

____
(Print Name)

STATEMENT OF WITNESSES

I declare under penalty of perjury that the principal has identified himself or herself to me, that the principal signed or acknowledged this durable power of attorney in my presence, that I believe the principal to be of sound mind, that the principal has affirmed that the principal is aware of the nature of the document and is signing it voluntarily and free from duress, that the principal requested that I serve as witness to the principal's execution of this document, that I am not the person appointed agent by this document, and that I am not a provider of health or residential care, an employee of a provider of health or residential care, the operator of a community care facility, or an employee of an operator of a health care facility.

I declare that I am not related to the principal by blood, marriage or adoption and that to the best of my knowledge I am not entitled to any part of the estate of the principal on the death of the principal under a will or by operation of law.

Witness Signature: ____
Print Name: ____
Date: ____
Address: ____

Witness Signature: ____
Print Name: ____
Date: ____
Address: ____

DIRECTIVE TO PHYSICIANS
(Patient is decision-maker)

Directive made this _____day of ______________________________(month, year).

I, ____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth in this directive.

l. If at any time I should have an incurable or irreversible condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, and if the application of life-sustaining procedures would serve only to artificially postpone the moment of my death, and if my attending physician determines that my death is imminent or will result within a relatively short time without the application of life-sustaining procedures, I direct that those procedures be withheld or withdrawn, and that I be permitted to die naturally.

OPTIONS

a. I further direct that when I become comatose, or when I become so weak that I cannot swallow water and food, that no feeding tube or other similar artificial apparatus be attached to or inserted into any part of my body to provide nourishment or to prevent dehydration.

PATIENT CHOOSES THIS OPTION_________________ (initials)

PATIENT DECLINES THIS OPTION_________________ (initials)

b. It is my intention that artificial means of support, including nutrition and hydration, be withheld or withdrawn if I should be diagnosed as being a permanently unconscious state where, in reasonable medical probability, there will not be a return of cognitive brain function enabling me to think and live in a human way.

PATIENT CHOOSES THIS OPTION__________________ (initials)

PATIENT DECLINES THIS OPTION__________________ (initials)

EXCEPTION(S) I do not authorize the following: ____________________________________
____
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____

2. In the absence of my ability to give directions regarding the use of those life sustaining procedures, it is my intention that this directive be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

3. (Female patients) If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no effect during my pregnancy.

4. I understand the full impact of this directive and I am emotionally and mentally competent to make this directive.

5. This directive shall be in effect until it is revoked.

6. I understand that I may revoke this directive at any time.

7. If I am incompetent, or otherwise mentally incapable of communication, I designate ______________________________, to make treatment decisions concerning my medical condition, including decisions carrying out the terms of this directive.

Signed: ____

Address: ____
(City, County, State of Residence)

WITNESSES

I am not related to the declarant by blood or marriage; I would not be entitled to any portion of the declarant's death. I am not the attending physician of the declarant or an employee of the attending physician. I am not a patient in the healthcare facility in which the declarant is a patient. I have no claim against any portion of the declarant's estate on the declarant's death. Furthermore, if I am an employee of a health facility in which the declarant is a patient, I am not involved in providing direct patient care to the declarant and am not directly involved in the financial affairs of the health facility.

Witness:_______________________________________

Witness:_______________________________________

CONSENT TO A “DO NOT RESUSCITATE” ORDER
(by patient)

Consent given this ______day of ______________________________(month, year).

I,____, being of sound mind, willfully and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

1. In the event that I suffer cardiac or respiratory arrest, I direct that no cardiopulmonary resuscitative (“CPR”) measures be performed. My attending physician, Dr. _______________________, measures the benefits and harm if they are performed, and the benefits and harm if they are not performed. I am satisfied with these explanations. I understand that CPR does not refer to ordinary methods used to maintain my life, health, or comfort, such as the administration of pain aid, other appropriate medication, IV fluids and nutritional support.

I consent to the issuance of a “Do Not Resuscitate” order by my attending physician.

Limitation(s). I do not authorize the following:____
____
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____
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2. In the absence of my ability to give directions regarding the use of CPR measures, it is my intention that this directive shall be honored by my family and physicians as the final expression of my right to refuse CPR measures and accept the consequences from such refusal.

3. (Female Patient): If I have been diagnosed as pregnant and that diagnosis is known to my physician, this consent shall have no force or effect during the course of my pregnancy.

4. I understand the importance of this consent, and I am emotionally and mentally competent to give this consent.

5. This consent shall be in effect until it is revoked. I understand that I may revoke this consent at any time.

6. I hereby release the Hospital, its personnel, my attending physician, and any other persons participating in my care from any responsibility whatsoever for unfavorable results, including death, which I understand may occur as a result of this refusal to permit CPR measures.

Signed:___________________________ Date:__________________________

Address:__________________________

____

WITNESSES

I am not related to the declarant (patient) by blood or marriage; nor would I be entitled to any portion of the declarant's estate on his/her decease; nor am I the attending physician of the declarant or an employee of the attending physician; nor am I a patient in the Hospital in which the declarant is a patient, or any person who has a claim against any portion of the estate of the declarant upon his/her decease. Furthermore, if I am an employee of the Hospital in which the declarant is a patient, I am not involved in providing direct patient care to the declarant nor am I directly involved in the financial affairs of the Hospital.

Witness: ___________________________	Witness:_______________________
Address: ___________________________	Address:_______________________
___________________________	______________________
Date:______________________________	Date: __________________________