

ADVANCE DIRECTIVE FORMS and MY RIGHTS TO GUIDE MY HEALTH CARE

NAME: _____ DATE OF BIRTH: _____
SSN: XXX - XX - _____ (last 4 digits only)

I am at least 18 years old, and of sound mind. I have received information regarding my rights to make advance directives and I understand the following statements.

- Federal and state laws say I can write down my choices now for future health care decisions. If someday I am sick or injured and cannot make health care decisions for myself, written advance directives can help guide my physicians and others in making treatment plans or in the use of life-sustaining (life-prolonging) procedures.
- **I can use Part A** of this form to name another person to talk to my physicians and make health care decisions for me if I cannot, (this is one type of advance directive and is often called a durable power of attorney for health care or health care proxy);

AND/OR

- **I can use Part B** of this form to directly tell my physicians about my choices if I become unable to tell them myself in the future (this is another type of advance directive and is often called a health care directive, declaration or living will).
- No one can require me to sign an advance directive. I have the right to choose to not do an advance directive at all.
- This information and these forms have been provided for my convenience. I may use another form of an advance directive or I may use this form with changes or additions. My health care providers can help me with questions and provide more information. My advance directive will be made a part of my medical record if I give a copy of it to my providers. Some states also have an advance directive registry where I may file my documents so others can find them when needed. A copy of an advance directive is valid. It is helpful if I also let others in my life know my choices and have a copy of my advance directive(s).
- Advance directives are not to be used for euthanasia, assisted suicide or any deliberate or affirmative act or omission to shorten or end life in a manner not permitted by law.
- For the purposes of these documents, medical treatment and procedures are referred to as life-sustaining (life-prolonging) if their use would only prolong the dying process or maintain the patient in a persistently unconscious state.
- I may choose to forgo life-sustaining (life-prolonging) treatments and procedures which are burdensome or disproportionate without reasonable hope of recovery.
- Comfort care and pain relief always will be given to me.
- While I have a right to consent to or to refuse treatment, I may not likely be offered treatment which is considered ineffective or futile by my health care providers.
- While I am pregnant, my advance directive to forgo life-sustaining treatment may not be followed under state law, except under special circumstances.
- I may revoke an advance directive any time; signing a new advance directive cancels previous ones.
- For more information on The Patient Self-Determination Act of 1990 or state laws on advance directives, I may contact the state attorney general, consult my attorney or health care provider or visit **mercy.net**.
- My health care provider is to let me know if my advance directive choices and instructions cannot or will not be followed, and is to transfer my care to another provider or facility in that event.

**PART A. DURABLE POWER OF ATTORNEY FOR HEALTH CARE (Health Care Proxy)
To Appoint Another Person ("Agent/Proxy") To Make Health Care Decisions
When I Can No Longer Make Them**

NAME: _____ DATE OF BIRTH: _____
SSN: XXX - XX - _____ (last 4 digits only)

This is a Durable Power of Attorney for Health Care and the authority of my Agent/Proxy, when effective, shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive.

1. I want to name another person to make decisions about my health care if I am not able to decide for myself any more. The person I name as my Agent/Proxy may then have access to my health information and medical records and will be my personal representative with the power and authority to: choose my health care providers and place of care (including my home); make decisions about my treatment; and consent to, refuse or withdraw treatment, including life-sustaining (life-prolonging) procedures.
2. This document becomes effective when I am unable to make and communicate decisions as certified by two of my physicians or as otherwise permitted by law. I may initial here to let just one physician certify (in Missouri):

_____ One physician may certify my inability to make health care decisions.
Initials

3. AGENT/PROXY:

A. I appoint the following person as my true and lawful Agent/Proxy, (also called attorney-in-fact):

Name: _____
Address: _____
Phone(s): 1st _____ 2nd _____

B. Alternate Agent/Proxy (optional). If the person above is not willing or available to make health care decisions for me, or if we are divorced or legally separated in the future, then I appoint the following person in the order below as my alternate Agent/Proxy and to have the powers described herein.

First Alternate Agent/Proxy

Name: _____
Address: _____
Phone(s): 1st _____
Phone(s): 2nd _____

Second Alternate Agent/Proxy

Name: _____
Address: _____
Phone(s): 1st _____
Phone(s): 2nd _____

4. ARTIFICIALLY-SUPPLIED NUTRITION AND HYDRATION: My health care Agent/Proxy is authorized to make whatever medical treatment decisions I could make if I were able, AND further:

(Initial only one below.)

_____ **I DO AUTHORIZE** my Agent/Proxy to direct a health care provider to withhold or withdraw artificially-supplied nutrition and hydration (including tube feeding of food and water) as permitted by law;*

OR

_____ **I DO NOT AUTHORIZE** my Agent/Proxy to direct a health care provider to withhold or withdraw artificially-supplied nutrition and hydration (including tube feeding of food and water) as permitted by law;*

* (In a Mercy health care facility, nutrition and hydration may be withheld or withdrawn if I have an irreversible condition which is end-stage or terminal AND if means of preserving my life have likely risks and burdens which outweigh the expected benefits or are disproportionate without a reasonable hope of benefit.)

PART B: HEALTH CARE DECLARATION/LIVING WILL
My Choices About Life-Sustaining Treatment and Other Care

NAME: _____ DATE OF BIRTH: _____
SSN: XXX - XX - _____ (last 4 digits only)

If I am not able to make and communicate health care decisions, then my physicians are to follow my written choices for the use of life-sustaining (life-prolonging) treatments if I have an irreversible condition which is end-stage or terminal or where thought and awareness of self and environment are absent (persistently unconscious). This is in exercise of my right to determine the course of my health care and to provide clear and convincing proof of my choices and instructions. My physicians and Agent/Proxy are to reasonably try to follow my choices and instructions as shown by my initials below:

1. _____ I direct and authorize my health care provider to withhold or withdraw ALL life sustaining (life-prolonging) treatment and procedures as permitted by law.*

OR

By my initials below, I make the following specific choices to show what treatments I DO NOT WANT to receive:

- _____ surgery or other invasive procedure;
- _____ antibiotics;
- _____ mechanical ventilator (respirator);
- _____ radiation therapy;
- _____ heart-lung resuscitation (CPR);
- _____ dialysis;
- _____ chemotherapy;
- _____ other "life-prolonging" medical or surgical procedures that are merely intended to keep me alive without reasonable hope of improving my condition or curing my illness or injury.

However, if my physician believes that any life-sustaining (life-prolonging) procedure may lead to recovery significant to me, then I direct my physician to try the treatment for a reasonable period of time. If it does not cause my condition to improve, I direct the treatment to be withdrawn even if it shortens my life. I also direct that I may be given 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.

2. **ARTIFICIAL NUTRITION AND HYDRATION** - I further make the following choice as indicated by my initials below:
(Initial only one below.)

_____ **I DO AUTHORIZE** my health care provider to withhold or withdraw artificially-supplied nutrition and hydration (including tube feeding of food and water) as permitted by law;*

OR

_____ **I DO NOT AUTHORIZE** my health care provider to withhold or withdraw artificially-supplied nutrition and hydration (including tube feeding of food and water) as permitted by law;*

* (In a Mercy health care facility, nutrition and hydration may be withheld or withdrawn if I have an irreversible condition which is end-stage or terminal AND if means of preserving my life have likely risks and burdens which outweigh the expected benefits or are disproportionate without a reasonable hope of benefit.)

3. ADDITIONAL CHOICES AND INSTRUCTIONS - Other important choices and instructions for my health care which are not described somewhere else in this document may be described below. (For example, these might be social, cultural, or faith-based choices for care, or choices about treatments such as feeding tubes, blood transfusions, or pain medications. Statements about my significant values or goals for recovery or care may be included below.)

(If no additional choices or instructions, please mark through this box with an X and initial.)

SIGNATURE FOR PART B

IN WITNESS WHEREOF, I signed this Health Care Declaration/Living Will
on this _____ day of _____, in the year _____.

Signature **Address**

Printed Name

WITNESSES FOR PART B

WITNESSES: The above Health Care Declaration/Living Will (Part B) was voluntarily signed in my presence on this _____ day of _____, in the year _____. I am at least 18 years old and am not related to, not financially responsible for the health care of, and am not an heir to, the person who signed the document.

Signature: _____ Signature: _____

Print Name: _____ Print Name: _____

Address: _____ Address: _____
