Advance Directives

While life is full of unforeseen events, some can be appropriately planned for.

CITIZENS
HEALTH

The forms included in this brochure are legal documents.

The forms included in this brochure are legal documents. You do not need an attorney to complete the documents but many persons do this with an attorney when they complete their will or trusts. Contact Kansas Health Ethics, Inc. (KHE) at (316) 684– 1991 if you have any questions and would like assistance with the documents in this brochure.

These forms have been reviewed by:
The Medical Society of Sedgwick County
Kansas State Nurses Association, District Six

Go to www.kansashealthethics.org for more information on Advance Directives.

After completing the documents: Durable Power of Attorney for Healthcare *or* Living Will:
When you sign the documents, make sure they are witnessed OR notarized. If you sign an advance directive, make at least five copies of your document and give them to your healthcare agent(s), your doctor(s), your lawyer, your spiritual leader or anyone else who may be involved with your healthcare. Make sure your agent, family, and friends know where your documents are kept. Please keep your originals in a safe place and one copy where it is easy to find and make more copies if needed. It is your job – not your doctor's—to have a copy ready when it is needed. Take a copy with you when you go into a hospital, nursing home, hospice or other care facility. KHE does not keep a copy of your documents on file.
A copy of the legal documents has the same effect as the original.

Use this space to list the people you have given copies to:

Name:____
Address: ____
City: __________________ State: ________ Zip: _________
Phone (Daytime): ____________ (Evening):_____________
Date: ____________

Name:____
Address: ____
City: __________________ State: ________ Zip: _________
Phone (Daytime): ____________ (Evening):_____________
Date: ____________

Name:____
Address: ____
City: __________________ State: ________ Zip: _________
Phone (Daytime): ____________ (Evening):_____________
Date: ____________

Name:____
Address: ____
City: __________________ State: ________ Zip: _________
Phone (Daytime): ____________ (Evening):_____________
Date: ____________

Name:____
Address: ____
City: __________________ State: ________ Zip: _________
Phone (Daytime): ____________ (Evening):_____________
Date: ____________

Name:____
Address: ____
City: __________________ State: ________ Zip: _________
Phone (Daytime): ____________ (Evening):_____________
Date: ____________

COMMONLY ASKED QUESTIONS:

What is a durable power of attorney for healthcare?
The Durable Power of Attorney for Healthcare (DPOA-HC) is a document allowing you to name a healthcare agent to make healthcare decisions for you only when you cannot make decisions for yourself. Your healthcare agent may consult with your caregivers and decide on a plan for your care. Your agent must tell caregivers what you would and would not choose as certain treatments.

Who is a healthcare agent?
The healthcare agent can be a family member or friend, a person you trust who knows your religious and other values and who is willing to make healthcare choices for you. Make sure your healthcare agent knows how you feel about quality-of-life choices, hospitalization, hospice, experimental treatments or life sustaining treatments. Your healthcare agent must follow your wishes. Your care-givers must respect the choices your healthcare agent makes for you.

How is the healthcare power of attorney different from a regular power of attorney?
The healthcare power of attorney covers ONLY healthcare. The regular Power of Attorney covers financial matters and property decisions. You may choose the same agent for all your affairs, but it is important to use a separate document/ directive for healthcare because your doctor, hospital and others will need copies.

How do I start the discussion about end-of-life and advance directives?
Talking about these issues may not be easy; there may be resistance, even denial. Many people are uncomfortable talking about living at the end-of-life. Start the conversation by telling your loved ones this is important to you. Eventually we are all going to die. You have been thinking about the kinds of treatment you would want and want to share your thoughts with them. If loved ones have to make decisions for you it may be difficult, but discussing your choices now can help them.

WHAT IS ADVANCED CARE PLANNING?

Advance Care Planning is a process for helping you understand possible future health care choices. Reflect on your own values and goals and discuss your choices with those persons closest to you. You may also put your wishes in writing in case you become unable to make your own decisions in the future.

YOUR healthcare and end of life decisions may be the most important choices facing you in the future. People are better prepared to make difficult end-of-life decisions if they understand their overall healthcare status. Ask questions of your physician(s) about your health.

YOU should decide about the kind of care you want while you are able to make your own decisions.

THINK about what you would want done for you.

TALK with your family and friends about your health care and end-of-life decision making. Advance care planning is all about making choices for yourself and communicating with family and friends about end-of-life care.

ACT Complete the attached forms and share with your family, physician, health care agent and attorney.

DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

DECISION TO NAME SOMEONE TO SPEAK FOR ME

I, (your name)_____(date of birth)_____, appoint the following person(s) to make healthcare decisions for me when I am unable to make or communicate my own wishes:

Agent may not be the treating healthcare provider, an employee of the treating healthcare provider, or an employee, owner, director or officer of a facility, unless that person is a relative or is bound to you by common vows to a religious life.

PLEASE PRINT:

Name of Agent: _____ _____ _____

Telephone Telephone

Agent's address:_____ City_____State/Zip _____

Name of First Alternate Agent: _____ _____ _____

Telephone Telephone

Agent's address:_____City_____State/Zip _____

This power of attorney for healthcare decisions shall become effective when I am unable to make decisions or unable to communicate my wishes regarding healthcare. This power of attorney for healthcare decisions shall not be affected by my subsequent disability or incapacity. Any durable power of attorney for healthcare decisions I have previously made is hereby revoked.

AUTHORITY GRANTED

My healthcare agent may:

1. Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition;
2. Make all arrangements for me at any hospital, treatment facility, hospice, nursing home or similar institution;
3. Employ or discharge healthcare personnel including physicians, psychiatrists, dentists, nurses, therapists or other persons who provide treatment for me;
4. Request, receive and review any information, spoken or written, regarding my personal affairs or physical or mental health including medical and hospital records, and exe- cute any releases or other documents that may be required in order to obtain such information; and
4. Make decisions about organ and tissue donations, autopsy and the disposition of my body.

My agent shall authorize consent for the following special instructions:

I wish to be a donor for organs and tissues.
I have attached information about treatment choices I wish to have honored by my agent._____ page(s) attached.

LIMITATIONS ON AUTHORITY GRANTED

My healthcare agent may not:

exceed the powers set out in writing in this document; *or*
Revoke any existing Living Will Declaration I may have.

X _____ _____
Signature Date

Notary Public:

Notary Seal:

State of_____County of _____

This instrument was acknowledged before me this_____day of_____(month, year)

Signature of Notary_____

or

Witnesses: (witnesses may not be the agent or a relative, or beneficiary of the principal)

X _____ Date: _____

(Signature)

X _____ Date: _____

(Signature)

LIVING WILL DECLARATION

Kansas Natural Death Act

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

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this decision. any Living Will declaration I have previously made is hereby revoked.

Declarations made this_____(day) of_____(month, year)

Signature:

X _____Date of Birth _____

Address: _____

street **city** **state** **zip**

This document must be witnessed by two individuals *or* acknowledged by a notary public.

Notary Public: Notary Seal:

State of_____County of _____

This instrument was acknowledged before me this_____day of_____(month, year)

Signature of Notary_____

or

Witnesses:

The declarant has been personally known to me and I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly responsible for declarant's medical care.

Name: _____ Name: _____

address: _____ address: _____

City, State, Zip: _____ City, State, Zip:_____

Nine issues to discuss with your family and friends

1. Beliefs
2. Health conditions
3. Life sustaining treatments
4. Vision of dying and death
5. Organ and tissue donation desired
6. Funeral arrangements
7. Documentation of wishes
8. Advance Directives and your treatment choices
9. Spokesperson(s)/ agent(s) you have chosen

When decisions have to be made for your health care in the future, prior conversations will help to convey your attitudes and values so your agents will know what treatment decisions they should make.

Organ and Tissue Donation

Share your decision with your family regarding your wishes about donation of organs or tissue.

Signing your driver's license and/or a donor card is an additional way to express your opinion.

At the time of your death, your family will be asked about donation.

Be sure your legal next of kin/family knows if you want to be a donor.

Transplantation is often the only hope for thousands of people suffering from organ failure or in need of corneas, skin, bone or other tissue.

For more information, contact: Midwest Transplant Network, 1035 N. Emporia, Ste 100, Wichita, KS 67214, (316) 262-6225

Treatment Directive

Some persons wish to put their directives (wishes) in writing so their family and friends know what they want done. This is an additional attachment to your legal documents.

The following lines are for you to write your own treatment wishes down.

Please date and attach to your Durable Power of Attorney for Healthcare Decisions.

_____

_____

Signature: _____ Date: _____

Notary Public:

State of _____ County of _____

This instrument was acknowledged before me this _____ day of_____month, year)

Signature of Notary: _____

Or

Witnesses: (witnesses may not be the agent or a relative, or beneficiary of the principal)

X _____(Signature) Date: _____

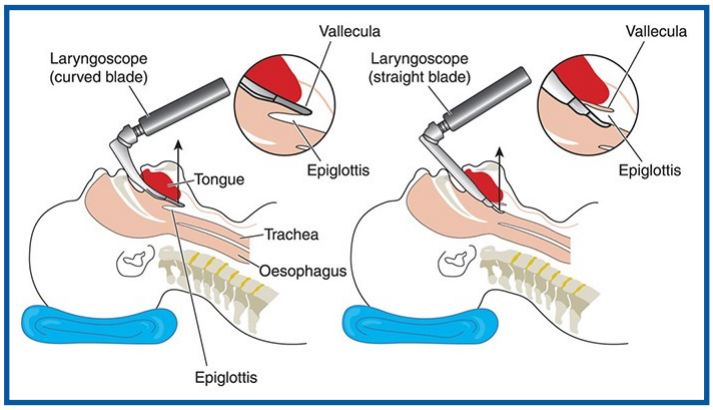
X _____(Signature) Date: _____

CARDIOPULMONONARY RESUSCITATION (CPR):

When a patient's heart or breathing suddenly stops, doctors, nurses, and other health care providers immediately start CPR. CPR stands for cardio (heart), pulmonary (lung) resuscitation and includes a number of emergency procedures to prevent death. If a patient's heart has stopped, rhythmic pressure over the sternum (breastbone) will compress the heart and pump blood through the body. If the heart beats erratically and ineffectively, a quick electrical shock to the heart through the chest wall may restore regular beating. When a patient stops breathing, it may be necessary to insert a tube into the windpipe (intubate), and then use a breathing machine (ventilator) to assist breathing. In any of these situations, the use of a number of medications would also be required. Patients routinely receive CPR when it is needed, unless a competent patient has requested DNR, or the family and attending physician have agreed to a written "Do Not Resuscitate" (DNR) order.

INTUBATION:

Insertion of a tubular device into a canal, hollow organ or cavity.



MECHANICAL VENTILATION:

Mechanical ventilation is provided through a tube inserted into the windpipe and connected to a breathing machine. It is frequently started during an emergency situation when a person has stopped breathing or breathing is inadequate to maintain life.

CHEMICAL TREATMENT/ DRUG THERAPY:

Chemical Treatment/ Drug Therapy is a chemical or medication treatment given to a patient to stimulate the heart to start beating. This treatment is generally used in addition to CPR and electrical therapies. Varioys medications will be given through the vein to chemically restart the heart.

ELECTRICAL CARDIAC CONVERSTAITON:

Electrical Cardiac Conversation, or electrical therapy, is the use of electricity to stimulate the heart to restart. This therapy may also be used to reset the heart when it is beating too fast. This will restore circulation. Two paddles are placed on the patient's chest and an electrical current is passed between them.

ARTIFICIAL NUTRITION (ENTERAL NUTRITIONAL SUPPORT):

Patients in the hospital are often not able to eat or drink. Under such circumstances they may be provided with artificial nutrition and hydration.

There are three ways artificial nutrition may be given:

1. A tube placed into the stomach through the nose (an NG tube)
2. A tube surgically placed directly into the stomach (gastrostomy tube)
3. An intravenous (IV) line with nutritional fluid called parenteral nutrition (TPN)

INTRAVENOUS HYDRATION:

Hydration fluids are given intravenously.

DIRECTIVES FOR RESUSCITATION

I, _____ (Patient), request the following Directives.

Please specify with initials:

_____ Full Cardiopulmonary Resuscitative Efforts (see attached)

OR

_____ NO Cardiopulmonary Resuscitations (CPR)

_____ NO Intubation and Mechanical Ventilation

_____ NO Chemical Treatment/ Drug Therapy

_____ NO Electrical Cardiac Conversion

_____ NO Intravenous Hydration

_____ NO Enteral Nutritional Support

I am aware that refusal of the above measures will not affect the quality of care provided, and every attempt will be made to ensure the comfort of the individual while respecting the rights and wishes of that individual to refuse life– sustaining measures.

This document is not final and may be changed and/ or canceled by the signer if the condition of the individual changes or other circumstances exist, after discussion with the physician.

I have read and I understand the significance of this document.

Signature: _____

Date: _____

Witness: _____

Physician: _____

DO-NOT-RESUSCITATE (DNR) DIRECTIVE

K.S.A 65-4941, Et. Seq.

DECISION TO LIMIT EMERGENCY MEDICAL CARE

I, (your name),_____, request that, effective today, emergency care for me will be limited as described below.

If my heart stops beating or if I stop breathing, no medical procedures to restart breathing or heart functioning will be instituted. No resuscitation will be attempted.

- I understand that the procedure I am refusing, known as cardiopulmonary resuscitation, (CPR), includes chest compressions, assisted ventilations, intubation, defibrillation, administration of cardiotonic medications and other related medical procedures.
- I do not intend for this decision to prevent me from obtaining other medical care, especially comfort measures and painmedication.
- I understand I may revoke this directive at any time.
- I give permission for this information to be given to emergency care providers, doctors, nurses or other health care personnel.
- This DNR directive shall remain in effect while I am admitted at a medical care facility or care home as well as during transport to or from a home or facility.

X _____ _____

(Signature) (Date)

X _____ _____

(Witness Signature) (Date)

Attending Physician Order: I have discussed the use of cardiopulmonary resuscitation with this patient and recognize the patient's decision to refuse CPR.

- In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation shall be attempted. **DNR**

X _____ _____

(Attending Physician's Signature) (Date)

_____ _____

(Address) (Facility, Clinic, or Hospital Name)

Revocation: I hereby withdraw the above DNR directive.

X _____ _____

(Signature) (Date)

DO-NOT-RESUSCITATE (DNR) DIRECTIVE

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NOTES:

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