ADVANCE DIRECTIVES FOR HEALTH CARE

HUNTER HEALTH

Your health care and end-of-life decisions may be the most important decisions you have to make. You can decide about the kind of care you want while you are able to make your own decisions.

Advance Directives are all about making choices for yourself and communicating with your family and friends about end-of-life care.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS (K.S.A. 58-625 through 632)

- It allows you to name an individual who can legally make health care decisions for you during a time of disability or incapacity. The designated agent is often referred to as your DPOA.
- The powers granted usually include: decisions about health care, choice of physicians, and long-term care.
- The terms of the form may include: refusing or withdrawing consent for the use of life-sustaining procedures, disposition of remains, or consent for organ donation and autopsy.
- The person signing the form must be a legal adult and competent when the document is signed.
- The individual who is appointed as your DPOA should be able to uphold your wishes for health care decisions in spite of their own preferences. It is important for the individual completing this form to share personal wishes and desires about health decisions with the named agent.
- The health care agent (DPOA) may not cancel a person's Living Will.

DECLARATION - LIVING WILL (K.S.A. 65-28, 101 ET.SEQ)

- This form allows you to state in advance that your dying process should not be artificially prolonged in case of a terminal illness.
- The Living Will applies only when the person has been diagnosed and certified terminally ill by two physicians.

  The Living Will gives your designated DPOA and physician directions for your end-of-life wishes.
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HEALTH CARE DIRECTIVE

- It allows you to state in advance specific treatment options you would or would not want to receive.
- This form can help DPOA understand your treatment preferences.
- This form may be filed in your medical record.

DO NOT RESUSCITATE ORDER REQUEST FORM (K.S.A. 65-4941.ET.SEQ)

- It allows you to elect to not have Cardio-Pulmonary Resuscitation (CPR) used when you are in a terminal state in your disease process. In the state of Kansas, it is required to have a physician's signature.
- This decision may be made only by you or your designated DPOA.
- This form states "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." This form does not stop treatment measures, it only stops resuscitation efforts.

DURABLE POWER OF ATTORNEY
FOR HEALTH CARE DECISIONS

HUNTER HEALTH

GENERAL STATEMENT OF AUTHORITY GRANTED

I, _____, (DOB) _____ , designated and appoint:

NAME OF AGENT: _____ PHONE: _____

ADDRESS: _____ CELL PHONE: _____

ALTERNATE AGENT: _____ PHONE: _____

ADDRESS: _____ CELL PHONE: _____

to be my agent for health care decisions and pursuant to the language stated below on my behalf to:

(1) Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition; and to make decisions about organ donation, autopsy and disposition of the body;

(2) Make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institutions; to employ or discharge health care personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists, or any other person who is licensed, certified, or otherwise authorized or permitted by the laws of this state to administer health care as the agent shall deem necessary for my physical, mental, and emotional well-being; and

(3) Request, receive, and review any information, verbal or written, regarding my personal affairs or physical or mental health including medical and hospital records and to execute any releases of other documents that may be required in order to obtain such information.

In exercising the grant of authority set forth above, my agent for health care decisions shall: be guided by my Healthcare Directive(s); or be guided by any previous discussions if no directives are established.

LIMITATIONS OF AUTHORITY:

(1) The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney of health care decisions, and shall not include the power to revoke or invalidate any previous existing declaration made in accordance with the natural death act.

(2) The agent shall be prohibited from authorizing consent for the following items: _____

This durable power of attorney for health care decision shall be subject to the additional following limitations:

(3) _____

EFFECTIVE TIME: This power of attorney for health care decisions shall become effective when I am unable to make decisions or unable to communicate my wishes regarding health care. This durable power of attorney for healthcare decisions shall not be affected by my subsequent disability or incapacity.

REVOCATION: Any durable power of attorney for health care decisions I have previously made is hereby revoked. This durable power of attorney shall be revoked by any instrument in writing executed, witnessed or acknowledged in the same manner as required herein or set out another manner of revocation, if desired.

EXECUTION: Executed this day _____ at _____ , Kansas.
DATE COUNTY

PRINCIPAL: _____
SIGNATURE

WITNESS:

This document must be (1) witnessed by two individuals of lawful age who are not the agent, not related to the principal by blood, marriage or adoption, not entitled to any portion of principle's estate and not financially responsible for principle's health care; or (2) acknowledged by a notary public.

WITNESS: _____ ADDRESS: _____

WITNESS: _____ ADDRESS: _____

(OR) NOTARY SEAL:

STATE OF: _____ COUNTY OF: _____

THIS INSTRUMENT WAS ACKNOWLEDGED BEFORE ME ON: _____ BY: _____

SIGNATURE OF NOTARY: _____ APPT EXPIRES: _____

DECLARATION - LIVING WILL

HUNTER HEALTH

Declaration made this _____ day of _____, 20____. _____ _____

I, _____, (DOB) _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, and 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 medicine 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 declaration.

SIGNATURE: _____ DATE: _____

LOCATION: _____, _____, KANSAS.
CITY COUNTY

WITNESS:

The declarant has been personally known to me and I believe the declarant to be of sound mind. I did not sign the declarant 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 or declarant or codicil thereto, or directly financially responsible for declarant's medical care.

WITNESS: _____ ADDRESS: _____

WITNESS: _____ ADDRESS: _____

(OR) NOTARY SEAL:

STATE OF: _____ COUNTY OF: _____

THIS INSTRUMENT WAS ACKNOWLEDGED BEFORE ME ON: _____ BY: _____

SIGNATURE OF NOTARY: _____ APPT EXPIRES: _____

ADVANCE DIRECTIVES FOR HEALTH CARE

HUNTER HEALTH

Declaration made this _____ day of _____, 20 _____. _____

I, _____, (DOB) _____, want everyone who cares for me know what health care I want.

An acceptable quality of life to me is one that includes the following capacities and values.

- ☐ Recognize my family or friends
- ☐ Feed myself
- ☐ Make decisions
- ☐ Take care of myself
- ☐ Communicate
- ☐ Be responsive to my environment
- ☐ Other _____

☐ I want my doctor to try treatments on a time-limited basis when the goal is to restore my health or help me experience a life in a way consistent with my values and wishes. I want such treatments withdrawn when they cannot achieve this goal or become too burdensome to me.

Among the time-limited treatments I would NOT agree to under any circumstances are:

- ☐ Resuscitation (CPR)
- ☐ Food or water by tube
- ☐ Antibiotics
- ☐ Dialysis
- ☐ Chemotherapy
- ☐ Surgery
- ☐ Ventilator
- ☐ Transfusions
- ☐ Other _____

☐ I always expect to be given care and treatment for pain or discomfort even if such care may affect how I sleep, eat, or breathe.

☐ I want my dying to be as natural as possible. Therefore, I direct that no treatment (including food or water by tube) be given just to keep my body functioning when I have a condition that will cause me to die soon, or a condition so bad that I have no reasonable hope of achieving a quality of life that is acceptable to me

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 except the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

I intend for this to be my direction to my physician(s), other health care providers, my family, and all others.

SIGNATURE: _____ DATE: _____

LOCATION: _____, _____, KANSAS.
CITY COUNTY

DO NOT RESUSCITATE (DNR) ORDER
REQUEST FORM

HUNTER HEALTH

DECISION TO LIMIT THE SCOPE OF EMERGENCY MEDICAL CARE

I, _____, (DOB) _____ , request limited emergency care for me 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 emergency or other medical care, especially comfort measures and pain medication, directed by a physician prior to my death.
- I understand that 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 form 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 for facility.
- I do hereby agree to the Do Not Resuscitate (DNR) and request an entry of a DNR Order. I intend for this to be my direction to my physician(s), other health care providers, my family, and all others.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

Should Durable Power of Attorney of Healthcare Decisions be in effect, the DPOA is agreeing and consenting to the wishes of a DNR with much consideration of the patient's best interest in mind:

DPOA SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

ATTENDING PHYSICIAN ORDER

I affirm this directive is the expressed wish of the patient, is medically appropriate, and is documented in the patient's permanent medical record. In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation shall be attempted. This is a DNR ORDER.

SIGNATURE: _____ DATE: _____

REVOCATION PROVISION

I hereby withdraw the above declaration.

SIGNATURE: _____ DATE: _____