TO ALL CONCERNED WITH MY CARE:
These instructions express my wishes about my health care. I want everyone concerned with my care to act in accord with them. My Patient Advocate or successor may act only if I am unable to participate in making decisions regarding my medical treatment.

I APPOINT THE FOLLOWING PERSON AS MY PATIENT ADVOCATE (PT.AD.):

Patient Advocate's Name: _____

Address: _____

I APPOINT THE FOLLOWING PERSON(S), IN THE ORDER LISTED, AS MY SUCCESSOR PATIENT ADVOCATE IF MY PATIENT ADVOCATE DOES NOT ACCEPT MY APPOINTMENT, IS INCAPACITATED, RESIGNS, OR IS REMOVED:

Name: _____

Address: _____

Name: _____

Address: _____

GENERAL INSTRUCTIONS:

My PT.AD. shall have the authority to make all decisions and to take all actions regarding my care, custody, and medical treatment including, but not limited to, the following:

a. Have access to, obtain copies of, and authorize release of my medical and other personal information;

b. Employ and discharge physicians, nurses, therapists, and any other health care providers;

c. Consent to, refuse, or withdraw for me any medical care; diagnostic, surgical, or therapeutic procedure; or other treatment of any type or nature, including life-sustaining treatment. I understand that life-sustaining treatment includes, but is not limited to, breathing with the use of a machine, and receiving food, water, and other liquids through tubes. I also understand that these decisions could or would allow me to die. I have listed below any specific instructions I have, related to life-sustaining treatment.

SPECIFIC INSTRUCTIONS:

My PT.AD. is to be guided in making medical decisions for me by what I have told him/her about my personal preferences regarding my care. My preferences are recorded below:

a. Specific Instructions Regarding Care I Do Want:

_____

_____

DURABLE POWER OF ATTORNEY

Patient Identification

Name:

Number:

D.O.B.:

Distribution: White – Health Record; Canary – Institutional File; Pink – Prisoner

b. Specific Instructions Regarding Care I Do Not Want:

_____

_____

c. Specific Instructions Regarding Life-Sustaining Treatment:

I understand that I do not have to choose one of the instructions regarding life-sustaining treatment listed below. If I choose one, I will sign below my choice.

If I sign one of the choices listed below, I direct that reasonable measures be taken to keep me comfortable and relieve pain.

CHOICE 1: I do not want my life to be prolonged by providing or continuing life-sustaining treatment if any of the following medical conditions exist:

I am in an irreversible coma or persistent vegetative state.

I am terminally ill and life-sustaining procedures would serve only to artificially delay my death.

Under any circumstances where my medical condition is such that the burdens of the treatment outweigh the expected benefits. In weighing the burdens and benefits of treatment, I want my PT.AD. to consider the relief of suffering and the quality of my life, as well as the extent of possibly prolonging my life.

I understand that this decision could or would allow me to die.

If this statement reflects your desires, sign here:

_____

CHOICE 2: I want my life prolonged by life-sustaining treatment unless I am in a coma or vegetative state which my doctor reasonably believes to be irreversible. Once my doctor has reasonably concluded that I will remain unconscious for the rest of my life, I do not want life-sustaining treatment to be provided or continued.

I understand that this decision could or would allow me to die.

If this statement reflects your desires, sign here:

_____

CHOICE 3: I want my life to be prolonged to the greatest extent possible consistent with sound medical practice without regard to my condition or to the chances I have of recovery. I direct life-sustaining treatment be provided in order to prolong my life.

If this statement reflects your desires, sign here:

_____

Patient Identification

Name:

Number:

D.O.B.:

d. Employ and discharge physicians, nurses, therapists, and any other health care providers;

My religious beliefs prohibit a medical examination to determine whether I am unable to participate in making medical treatment decisions. I desire this determination to be made in the following manner:

_____

_____

This document is to be treated as a Durable Power of Attorney for Health Care and shall survive my disability or incapacity. If I am unable to participate in making decisions for my care, and there is no PT.AD. or successor PT.AD. able to act for me, I request that the instructions I have given in this document be treated as conclusive evidence of my wishes. It is also my intent that anyone participating in my medical treatment shall not be liable for following the directions of my PT.AD. that are consistent with my instructions.

Photocopies of this document can be relied upon as though they are originals.

I am providing these instructions of my free will. I have not been required to give them in order to receive care or have care withheld or withdrawn. I am at least eighteen (18) years old and of sound mind.

SIGNATURE:

Sign Name: _____

Date: _____

Print Name: _____

WITNESS STATEMENT AND SIGNATURES:

I declare that the person who signed this Designation of Patient Advocate signed in my presence and is known to me. I also declare that the person who signed appears to be of sound mind and under no duress, fraud, or undue influence, and is not my husband or wife, parent, child, grandparent, brother or sister. I declare that I am not a known beneficiary of her/his will at the time of witnessing, her/his physician, insurance provider for the person who signed, an employee of a health facility that is treating her/him, or an employee of a home for the aged where she/he resides, and that I am at least eighteen (18) years of age.

WITNESS:

Sign Name: _____

Print Name: _____

Address: _____

Date: _____

Sign Name: _____

Print Name: _____

Address: _____

Date: _____

DURABLE POWER OF ATTORNEY

Patient Identification

Name:

Number:

D.O.B.: