CHRISTIAN FAMILY MEDICINE

End of Life Conversation Tips and Forms

This is a tool to aid you and your family to make decisions that will affect you and your family when you are dealing with the end of life.

This packet includes:

Durable Power of Attorney for Health Care Choices information and form
Healthcare Directive information and form

Why are these important:

Durable Power of Attorney for Health Care Choices

This will let you name someone whom you trust to make decisions about your healthcare. This becomes effective immediately or when your doctor or your doctor and one other doctor certify that you are unable be reason of any physical or mental condition to receive and evaluate health care treatment information or to communicate health care decisions.

Healthcare Directive

This is similar to a living will by letting you state your wishes about health care in the event that you can no longer speak for yourself. This allows you to choose specific treatments that you wish to be withheld or withdrawn in the event you have a terminal illness or are persistently unconscious. This also allows you to make choices regarding organ donation. Your Health Care Directive becomes effective when you can no longer make or communicate your health care decisions.

Legalizing these forms:

In order for these forms to be considered legal documents they must be filled out by someone that is 18 years of age or older with a sound mind. Your signature must be both witnessed and notarized. Once this is done, you should keep a copy for your records, provide your agent a copy and provide your physician's office a copy for your legal medical record. It is also beneficial to have a copy of this with you when you go to the hospital or travel.

Picking your agent:

Your agent should be someone you trust. Usually a family member or close friend that knows your end of life desires and is willing to accept this responsibility. This cannot be your physician or an owner or an employee of the healthcare facility you reside unless the person is a relative. If at any time you change your mind, the directive can be revoked by a written notice of revocation.

Note: This packet is not a substitute for legal advice. These are simply tools to help you make decisions. If you want more information about how these will affect you legally, please contact an attorney.

Instructions for completing the Health Care Directive

1. Read the Directive carefully and in its entirety before signing or initialing any part.

2. Review the list of life-prolonging procedures and decide which, if any, of these procedures **you would like to have withheld or withdrawn**. Write your initials next to each procedure you want to be withheld or withdrawn if you are persistently unconscious or there is no reasonable expectation of your recovery from a seriously incapacitating terminal illness or condition.

3. If you have chosen to execute a Health Care Directive, and you have initialed all the appropriate spaces, in front of two witnesses sign and date the form on the appropriate line.

4. It is your responsibility to inform and discuss your wishes with your family, doctor, minister, lawyer or anyone else you feel needs to be aware of your directive.

Process to revoke a Health Care Directive

If at any time you change your mind, the directive can be revoked by the following acts:

1. By obliterating, burning, tearing or otherwise destroying the declaration.

2. By a written revocation signed by you or your agent.

3. Notify anyone you had previously given a copy of your Health Care Directive of your decision to revoke your directive.

I make this Health Care Directive to exercise my right to determine the course of my health care and to provide clear and convincing proof of my wishes and instructions about my treatment.

If I am persistently unconscious or there is no reasonable expectation of my recovery from a seriously incapacitating or terminal illness or condition, **I direct that all of the life-prolonging procedures which I have initialed below be withheld or withdrawn**.

- Artificially supplied nutrition and hydration (including feeding tube for food and water.) ________
- Surgery or other invasive procedures ________
- Heart-lung resuscitation (CPR) ________
- Antibiotic ________
- Mechanical ventilator (respirator) ________
- Chemotherapy ________
- Radiation therapy ________
- All 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-prolonging procedure may lead to a significant recovery, I direct my physician to try the treatment for a reasonable period of time. If it does not improve my condition, I direct the treatment be withdrawn even if it shortens my life. I also direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or breathing, or be habit-forming.

If I have not designated an agent in the Durable Power of Attorney, this document is meant to be in full force and effect as my Health Care Directive.

You must sign this document in the presence of two witnesses.

In witness whereof, I have executed this document this ______ day of ______________, 20___

____
Signature

The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses is at least eighteen years of age.

Signature	__________________________	Signature	__________________________
Print name	__________________________	Print name	__________________________
Address	__________________________	Address	__________________________

Instructions for completing the Durable Power of Attorney for Health Care – Part II

1. Read the entire form carefully before signing or initialing any part.

2. Discuss this form with your family and close friends. Include anyone who may be asked to make decisions concerning your future health care if you are unable to do so.

3. Complete section 1, **Selection of Agent**. Enter the name address and telephone number of the person you choose as your agent and that has agreed to assist with this task.

4. Section 2, **Alternate Agent.** This is only completed if you desire to have an alternate agent in case your original agent is not available.

5. Complete section 3, **Effective Date and Durability.** This form lets you choose whether one or two doctors need to certify that you are incapacitated. Incapacitated means that you are no longer able to make decisions for yourself and it is time for your agent to act on your behalf. If you want two doctors to make that decision, leave this section blank.

6. Complete section 4, **Agent's Powers**. You decide whether or not your agent can make decisions concerning withholding or withdrawing artificially supplied nutrition and hydration. Please indicate your decision in the space provided.

7. **Signature Completion**. If you have completed the durable Power of Attorney for Health Care, you will need to sign the form in the presence of a notary public who will then complete the notary block. You will also need two witnesses to sign the form. The notary does not need to see the witnesses sign.

8. Give a copy of the completed form to your family, close friends, doctor, lawyer, minister or anyone that may be asked to make decisions concerning your health care if you are unable to do so.

Process to revoke a Durable Power of Attorney for Health Care

If at any time you change your mind, the declaration can be revoked by doing the following.

1. By obliterating, burning, tearing or otherwise destroying the declaration.

2. By a written revocation signed by you or your agent.

3. Notify anyone that you previously gave a copy of the Durable Power of Attorney for Health Care that the form has been changed.

Durable Power of Attorney for Health Care Choices - Part II

Section 1 - Selection of an Agent, I appoint:

Name: ____

Address: ____

City/State: ____

Telephone: ____

Section 2 – Selection of an Alternate Agent, I appoint:

Name: ____

Address: ____

City/State: ____

Telephone: ____

This is a Durable Power of Attorney, and the authority of my Agent shall not terminate if I become disabled or incapacitated.

Section 3 – Effective Date and Durability:
This Durable Power of Attorney is effective when **TWO** physicians decide and certify that I am incapacitated and unable to make and communicate a health care decision.

- It is my desire to have **ONE** physician, instead of **TWO**, to decide whether I am incapacitated. [______] **Initials**

Section 4 – Agent's Powers, I grant to my Agent full authority to:

A. Give consent to, prohibit or withdraw any type of health care, medical care, treatment or procedure, even if my death may result.

- I wish to **AUTHORIZE** my agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding or food and water). [______] **Initials**

- I wish to **DO NOT AUTHORIZE** my agent to direct a health care provider to withhold or withdraw artificially supplied nutrition and hydration (including tube feeding or food and water). [______] **Initials**

B. Make all necessary arrangements for health care services on my behalf, and to hire and fire medical personnel responsible for my care.

C. Move me into or out of any health care facility or state (even if against medical advise) to obtain compliance with the decisions of my Agent.

D. Take any other action necessary to do what I authorize here, including (but not limited to) granting any waiver or release from liability required by any health care provider, and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney.

Section 5, Agent's Financial Liability and Compensation:
My Agent acting under this Durable Power of Attorney will incur no personal financial liability. My Agent shall not be entitled to compensation for services performed under this Durable Power of Attorney, but my Agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provisions hereof.

You must sign this document in the presence of a Notary Public. You will also need two witnesses to sign this form.

IN WITNESS WHEREOF, I have executed this document this ______ day of _____________, 20_____.

______________________________________ ______________________________________

Signature **Printed Name**

The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses is at least eighteen years of age.

______________________________________ ______________________________________

Witness Signature **Witness Signature**

______________________________________ ______________________________________

Witness Printed Name **Witness Printed Name**

______________________________________ ______________________________________

Witness Address **Witness Address**

______________________________________ ______________________________________

Witness City/State/Zip **Witness City/State/Zip**

NOTARY PUBLIC REQUIRED FOR DURABLE POWER OF ATTORNEY – PART II
State of Missouri)

On this ______________ day of ________________________________, 20_____, before me personally appeared ____, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my had and affixed by official seal in the County of __________________________________, State of Missouri, the day and year first above written.

____

Notary Public

My Commission Expires: