Advance Directive

Saint Luke's Hospital
Kansas City, MO 64111

Healthcare Directive

If you only want to name a Durable Power of Attorney for Healthcare Decisions, draw a large "X" through the top portion of this page.

I, _____SS# _____ (optional) want everyone who cares for me to know what healthcare I want.

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 would consent to, and want my agent to consider my participation in federally regulated research related to my disorder or condition.

I want my doctor to try treatments and interventions 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 I want such treatments and interventions withdrawn when they cannot achieve this goal or become too burdensome to me.

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 (including substantial brain damage or brain disease) that I have no reasonable hope of achieving a quality of life that is acceptable to me.

An acceptable quality of life to me is one that includes the following capacities and values. Describe here the things that are most important to me when I am making decisions to choose or refuse life-sustaining treatments.

_____

_____

_____

Examples: ● recognize family or friends ● make decisions ●communicate
● feed myself ● take care of myself ● be responsive to my environment

I also want _____

Examples: ● to donate my organs ● hospice care ● to die at home

In facing the end of my life, I expect my agent (if I have one) and my caregivers to honor my wishes, values and directives.

If you do not agree with one or any of the above statements, draw a line through the statement and put your initials at the end of the line.

_____

Be sure to sign on page two even if no Durable Power of Attorney is appointed

Talk about this form and your ideas about your healthcare with the person you have chosen to make decisions for you, your doctor(s), family, friends and clergy. Give each of them a completed copy.

You may cancel or change this form at any time. You should review it often. Each time you review it, put your initials and the date/time below.

_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
Initials	Date/Time	Initials	Date/Time	Initials	Date/Time	Initials	Date/Time	Initials	Date/Time

This document is provided as a service by the Center for Practical Bioethics and Saint Luke's Hospital of Kansas City.

Patient Label:

Saint Luke's Hospital
Kansas City, MO 64111

Durable Power of Attorney for Healthcare Decisions

Take a copy of this document with you whenever you go to the hospital or on a trip

It is important to choose someone to make healthcare decisions for you when you cannot make or communicate decisions for yourself. Tell the person you choose what healthcare you want. The person you choose will be your agent. They will have the right to make decisions for your healthcare. If you DO NOT choose someone to make decisions for you, write NONE on the line for the agent's name. I, _____SS#_____ (optional) appoint the person named in this document to be my agent to make my healthcare decisions. This document is a Durable Power of Attorney for Healthcare Decisions. My agent's power shall not end if I become incapacitated or if there is uncertainty that I am dead. This document revokes any prior Durable Power of Attorney for Healthcare Decisions. My agent may not appoint anyone else to make decisions for me. My agent and caregivers are protected from any claims based on following this Durable Power of Attorney for Healthcare Decisions. My agent shall not be responsible for any costs associated with my care. I give my agent full power to make all decisions for me about my healthcare, including the power to direct the withholding or withdrawal of life-prolonging treatment. My agent is authorized to:

- Consent, refuse or withdraw consent to any care, procedure, treatment or service to diagnose, treat or maintain a physical or mental condition (including artificially supplied nutrition and hydration or tube feeding);
- Consent, refuse or withdraw consent to participate in federally regulated research related to my condition or disorder
- Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home or other healthcare organization; and, employ or discharge healthcare personnel (any person who is authorized or permitted by the laws of the state to provide healthcare services) as he or she shall deem necessary for my physical, mental or emotional well-being;
- Request, receive, review and authorize sending any information regarding my physical or mental health, or my personal affairs, including medical and hospital records; and execute any releases that may be required to obtain such information;
- Move me into or out of any State or other institution for the purpose of complying with my Healthcare Directive or the decisions of my agent;
- Take legal action, if needed, to do what I have directed;
- Make decisions about autopsy and organ donation and the disposition of my body in conformity with state law; and
- Become my guardian if one is needed

In exercising this power, I expect my agent to be guided by my directions as discussed with me prior to this appointment and guided by my Healthcare Directive (on page one).

If you **DO NOT** want the person (agent) you name to be able to do any of the above things, draw a line through the statement and put your initials at the end of the line.

Agent's name _____Phone _____Email_____

Address _____

Alternate Agent's name _____
(include name, address and telephone number)

If you **do not** want to name an alternate, write "none".

Execution and Effective Date of Appointment

My agent's authority is effective immediately for the limited purpose of having full access to my medical records and to confer with my healthcare providers and me about my condition. My agent's authority to make all healthcare and related decisions for me is effective when my primary physician determines that I am unable to make my own healthcare decisions.

_____

SIGN HERE for the Durable Power of Attorney and/or Healthcare Decisions form. Please ask two persons to witness your signature who are not related to you or financially connected to your estate. Many states require a notarization. It is recommended for the residents of all states.

Signature _____Date/Time _____

Witness _____Date/Time _____

Witness _____Date/Time _____

Notarization:

On this _____date of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of _____,State of _____, on the date written above.

Notary Public _____My Commission Expires _____

Patient Label: