LEGAL AND FINANCIAL PLANNING CONSIDERATIONS FOR MEMBERS OF THE ORANGE, CALIFORNIA STAKE

D/C 88:119: Organize yourselves; prepare every needful thing; and establish a house, even a house of prayer, a house of fasting, a house of faith, a house of learning, a house of glory, a house of order, a house of God.

In today's complex financial and health care world, proper planning is no longer an option, but a necessity. From an Estate Planning perspective, we need to be prepared for two possibilities, incapacity and death. While the first is possible (perhaps probable), the second is inevitable. Preparation is required.

INCAPACITY can be the result of (1) dementia, (2) Alzheimer's, or (3) physical impairment. As a general rule, incapacity is established by two doctors (for activation of many legal documents) or by a court. None of us want to experience incapacity, but current statistics indicate that as many as forty-eight percent (48%) of us will incur incapacity prior to death.

Two needs arise with incapacity: (1) financial needs and (2) health care decision needs. Two options are available for each need: (1) Plan or (2) Don't Plan.

Plan for **FINANCIAL NEEDS**: Planning includes an (1) Asset DURABLE POWER OF ATTORNEY document and (if advisable) (2) a living trust.

Plan for **HEALTH CARE DECISIONS:** several documents contribute to a completed plan for the health care decision process.

A. HEALTH CARE DIRECTIVE (or Health Care Power of Attorney Document). This document appoints the person of your choice with the authority to make health care decisions if you become unable to so act. California has a "statutory" form which is included in this package.
B. Also included is a HIPAA (Health Insurance Portability and Accountability Act) allowing the medical profession to release medical information to the person you designate with authority to make your health care decisions.
C. RIGHT TO DIE document: This document allows the person you name as your health care attorney-in-fact to remove artificial life support if it is only prolonging death and recovery is doubtful.
D. POLST

, a POLST declaration, and a Living Will. These documents are currently valid (2014) and operational, but the laws are constantly changing and there is no guarantee that these

documents will be valid in the future. An explanation of the purpose of each document is attached to the document.

No Plan: if we fail to plan, the legal option for both financial administration and health care decisions is a court procedure known as CONSERVATORSHIP. The legal option is expensive and burdensome.

PROPER PLANNING WILL PROVIDE YOU AND YOUR HEIRS PROTECTION AGAINST EXCESSIVE COSTS REQUIRED FOR ANY TYPE OF CONVALESCENT HEALTH CARE NEEDS AND WILL ALSO PROVIDE FOR THE EFFECTIVE AND EFFICIENT PASSING OF TITLE OF YOUR ASSETS

ADVANCED HEALTH CARE DIRECTIVE

This document appoints the person of your choice with the authority to make health care decisions for you if you are unable to make them yourself.

This document also offers options which you may use to instruct that person with regard to your preferences regarding those health care decisions.

This document must be signed in front of witnesses who are not related to you and who are not in the medical profession. Two witnesses are required.

ADVANCE HEALTH CARE DIRECTIVE FORM

Print Form | Reset Form

CALIFORNIA PROBATE CODE SECTION 4700-4701

4700. The form provided in Section 4701 may, but need not, be used to create an advance health care directive. The other sections of this division govern the effect of the form or any other writing used to create an advance health care directive. An individual may complete or modify all or any part of the form in Section 4701.

4701. The statutory advance health care directive form is as follows:

ADVANCE HEALTH CARE DIRECTIVE (California Probate Section 4701) Explanation

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. If you use this form, you may complete or modify all or any part of it. You are free to use a different form.

Part 1 of this form is a power of attorney for health care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be an operator or employee of a community care facility or a residential care facility where you are receiving care, or your supervising health care provider or employee of the health care institution where you are receiving care, unless your agent is related to your or is a coworker.)

Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

(a) Consent or refuse consent to any care, treatment, service, or procedure to maintain, diagnose, or otherwise affect a physical or mental condition.

(b) Select or discharge health care providers and institutions.

(c) Approve or disapprove diagnostic tests, surgical procedures,and programs of medication.

(d) Direct the provision, withholding, or withdrawal of artificial nutrition and hydration and all other forms of health care,including cardiopulmonary resuscitation.

(e) Make anatomical gifts, authorize an autopsy, and direct disposition of remains.

Part 2 of this form lets you give specific instructions about any aspect of your health care, whether or not you appoint an agent.Choices are provided for you to express your wishes regarding the provision, withholding, or withdrawal of treatment to keep you alive,as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes. If you are satisfied to allow your agent to determine what is best for you in making end-of-life decisions, you need not fill out Part 2 of this form.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a physician to have primary responsibility for your health care.

After completing this form, sign and date the form at the end.The form must be signed by two qualified witnesses or acknowledged before a notary public. Give a copy of the signed and completed form to your physician, to any other health care providers you may have,to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1.1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

_____

(name of individual you choose as agent)

_____ _____ _____ _____

(address) (city) (state) (ZIP Code)

_____ _____

(home phone) (work phone)

ADVANCE HEALTH CARE DIRECTIVE FORM

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:

_____

(name of individual you choose as first alternate agent)

_____ _____ _____ _____

(address) (city) (state) (ZIP Code)

_____ _____

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:

_____

(name of individual you choose as second alternate agent)

_____ _____ _____ _____

(address) (city) (state) (ZIP Code)

_____ _____

(home phone) (work phone)

(1.2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, except as I state here:

_____

_____

_____

(Add additional sheets if needed.)

(1.3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

If I mark this box ( ), my agent's authority to make health care decisions for me takes effect immediately.

(1.4.) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(1.5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here or in Part 3 of this form:

_____

_____

_____

(Add additional sheets if needed.)

ADVANCE HEALTH CARE DIRECTIVE FORM

(1.6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.

PART 2
INSTRUCTIONS FOR HEALTH CARE

If you fill out this part of the form, you may strike any wording you do not want.

(2.1) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below:

☐ (a) Choice Not to Prolong Life

I do not want my life to be prolonged if (1) I have an incurable and irreversible condition that will result in my death within a relatively short time, (2) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (3) the likely risks and burdens of treatment would outweigh the expected benefits, OR

☐ (b) Choice to Prolong Life

I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(2.2) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times, even if it hastens my death:

(Add additional sheets if needed.)

(2.3) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that:

(Add additional sheets if needed.)

PART 3
DONATION OF ORGANS AT DEATH
(OPTIONAL)

(3.1) Upon my death (mark applicable box):

☐ (a) I give any needed organs, tissues, or parts, OR

☐ (b) I give the following organs, tissues, or parts only.

☐ (c) My gift is for the following purposes (strike any of the following you do not want):

(1) Transplant
(2) Therapy
(3) Research
(4) Education

ADVANCE HEALTH CARE DIRECTIVE FORM

PART 4
PRIMARY PHYSICIAN
(OPTIONAL)

(4.1) I designate the following physician as my primary physician:

_____
(name of physician)

_____ _____ _____ _____
(address) (city) (state) (ZIP Code)

_____
(phone)

OPTIONAL: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:

_____
(name of physician)

_____ _____ _____ _____
(address) (city) (state) (ZIP Code)

_____
(phone)

PART 5

(5.1) EFFECT OF COPY: A copy of this form has the same effect as the original.

(5.2) SIGNATURE: Sign and date the form here:

_____
(print your name)

_____
(sign your name) (date)

_____ _____ _____ _____
(address) (city) (state) (ZIP Code)

(5.3) STATEMENT OF WITNESSES: I declare under penalty of perjury under the laws of California (1) that the individual who signed or acknowledged this advance health care directive is personally known to me, or that the individual's identity was proven to me by convincing evidence (2) that the individual signed or acknowledged this advance directive in my presence, (3) that the individual appears to be of sound mind and under no duress, fraud, or undue influence, (4) that I am not a person appointed as agent by this advance directive, and (5) that I am not the individual's health care provider, an employee of the individual's health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, nor an employee of an operator of a residential care facility for the elderly.

First witness

_____
(print name)

Second witness

_____
(print name)

ADVANCE HEALTH CARE DIRECTIVE FORM

(address)	(address)
(city) (state)	(city) (state)
(signature of witness)	(signature of witness)
(date)	(date)

(5.4) ADDITIONAL STATEMENT OF WITNESSES: At least one of the above witnesses must also sign the following declaration:

I further declare under penalty of perjury under the laws of California that I am not related to the individual executing this advance health care directive by blood, marriage, or adoption, and to the best of my knowledge, I am not entitled to any part of the individual's estate upon his or her death under a will now existing or by operation of law.

(signature of witness)	(signature of witness)

PART 6
SPECIAL WITNESS REQUIREMENT

(6.1) The following statement is required only if you are a patient in a skilled nursing facility--a health care facility that provides the following basic services: skilled nursing care and supportive care to patients whose primary need is for availability of skilled nursing care on an extended basis. The patient advocate or ombudsman must sign the following statement:

STATEMENT OF PATIENT ADVOCATE OR OMBUDSMAN

I declare under penalty of perjury under the laws of California that I am a patient advocate or ombudsman as designated by the State Department of Aging and that I am serving as a witness as required by Section 4675 of the Probate Code.

(print your name)

(sign your name) (date)

(address) (city) (state) (ZIP Code)

HIPAA/CMIA AUTHORIZATION
(HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)
AND
(CONFIDENTIALITY OF MEDICAL INFORMATION ACT)

This document authorized the person you name with health care decision responsibilities to receive information from the medical profession.

The HIPAA provisions are federal in nature and the CIMA reference is to California requirements.

Your health care decision maker must present this to the medical entity or individual holding your health care information in order for him or her to be able to receive information from or give direction to the person or entity providing the medical care.

This document must be signed and notarized to be legally binding.

HIPAA/CMIA AUTHORIZATION
(HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT)
AND
(CONFIDENTIALITY OF MEDICAL INFORMATION ACT)

I. IDENTIFICATION OF PRINCIPAL

MY NAME IS _____**(Print Name)**

NAME(S) OF MY AGENT(S)

1. _____ **or if unable**
2. _____ **or if unable**
3. _____ **or if unable**

II. AUTHORIZATION

By signing this authorization, acting without influence and of my own will, I hereby freely and voluntarily authorize the following:

A. I authorize **my agent(s)**, as so designated in any advance health care directive, Health Care power of attorney, of similar document (all hereafter referred to as "agent") to obtain my protected health information and medical information under the limitations and for the purpose(s) stated below.

B. I authorize **all health care providers** and covered entities to release my protected health and medical information to my agent(s) under the limitations and for the purpose(s) and term stated below. I further authorize **physicians** who are licensed, qualified, and familiar with my condition to render a written opinion regarding my capacity or incapacity under the limitations and for the purpose(s) stated below.

III. PURPOSE AND LIMITATIONS

A. PURPOSE/USE - The disclosure and receipt of my protected health and medical information shall be for the purposes of determining my capacity or incapacity to care for my own affairs either physically or mentally, or both, and activating my health care directive, springing durable power of attorney, estate planning power of

attorney, or living trust's successor trustee clause, as it may then be amended, and as it applies to the agent to whom the information is being transmitted.

B. LIMITATIONS – The disclosure shall be limited to the minimum health information sufficient to explain and support a determination of capacity or incapacity. Capacity or incapacity may be defined (1) by a physician who is licensed, qualified, and familiar with my condition, (2) by the document referencing the agent, or (3) as the physical and/or mental inability to care for personal affairs.

IV. REDISCLOSURE

I authorize my agent(s) to re-disclose my protected health and medical information to my attorney as my agent shall deem appropriate. I further authorize my attorney to release the same medical information to such banks, stock brokerages, escrow agents, financial managers or other personal or companies as shall be then administering assets in my name or in the name of a trust of which I am a Creator or co-Creator, for the sole purpose of obtaining signature access to such assets so as to able to administer said assets for and in my behalf. All other re-disclosure is prohibited, except as required or permitted by law.

V. TERM

This authorization shall remain in force unless and until I choose to revoke it, or until two years after the date of my decease.

VI. INDEMNIFICATION AND COMPLIANCE

I hereby release and hold harmless for myself and my agents any physician, health care agency, hospital, nurse and other medical person or entity, my agent, any bank, stock brokerage or other financial entity in which I have funds, any escrow, title insurance and real estate agency, for compliance with this document. Any person authorized above to receive my protected health information may bring a legal action against any covered entity or health care provider that refuses to provide my protected health information for the purposes described above.

VII. OTHER

I understand that:

A. I have a right to receive a copy of this authorization.

B. I may revoke or modify this authorization at any time by written notice delivered to and received by the health care provider.

C. The covered entity may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign an authorization unless the law allows conditions.

D. There is the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer protected by HIPAA regulations.

In witness whereof I have signed this authorization to be effective as of the date listed below:

_____ (sign here) DATE: _____

STATE OF CALIFORNIA)

COUNTY OF ORANGE

On _____ before me, _____ a Notary Public in and for the above county and state, personally appeared _____, proved to me on the basis of satisfactory evidence to be the person whose name is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument the person executed the instrument.

I certify under penalty of perjury under the laws of the State of California that the foregoing paragraph is true and correct.
WITNESS my hand and official seal.

_____
Notary's Signature

DIRECTIVE TO PHYSICIANS

(aka LIVING WILL OR RIGHT TO DIE Document)

This document expresses the concept that if you are in an irreversible situation and there is no hope of recovery, it is your desire that artificial life support be suspended or removed.

Though this is sometimes titled a "Physician's directive", the doctor does not make the decision. This decision is made by the person you name as having authority to make your health care decisions.

This document must be signed in front of witnesses who are not related to you and who are not in the medical profession. Two witnesses are required.

DIRECTIVE TO PHYSICIANS

By: _____ (Print Name)

This directive is made on _____(date), in the State of California.

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

1. If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death will occur in a relatively short time, without the administration of life-sustaining treatment, and further that I am in an irreversible coma or persistent vegetative state, and no longer able to make my own decisions, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally. I direct my attending physician to withhold or withdraw said treatment including hydration and nutrition which would only act to delay the point of death. However, I direct that such medicine, treatment, or other assistance as is available be applied to alleviate unnecessary pain and suffering and increase comfort.

2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive 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.

3. I understand the full import of this directive, and I am emotionally and mentally competent to make this directive.

Signed: _____

Printed Name: _____

The declarant on the date last above written, declared to us that the above instrument properly expresses his or her intent and requested us to act as witnesses to it. The declarant executed this document of the declarant's own free will in front of me, without any apparent duress or undue influence. I am not a health care provider, an employee of a health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility for the elderly, or an employee thereof, nor am I entitled to any portion of the estate of the declarant. I am of the age of majority.

Witness _____ Dated: _____

Witness _____ Dated: _____

(Note: Witnesses must not be related to you and cannot be providers of health care)

POLST

(Physician's Order for Life-Sustaining Treatment)

This document is generally used only by those who have an irreversible terminal illness. Under this document, you express your intent that if you stop breathing, or if your heart stops beating, it is your direction to terminate treatment and to otherwise let nature take its course.

This is the only document the emergency personnel (paramedics) will honor. If you determine to use this document, you need to have your doctor also sign as indicated.

This document should be produced on "hot pink" paper to make it more easily identifiable to emergency personnel.

The document requires no witness or notary, but must be countersigned by your primary care doctor.

2011 California POLST Form

Effective April 1, 2011

In order to maintain continuity throughout California, please follow these instructions:

****** Copy or print POLST form on 65# Cover Ultra Pink card stock. ******

Mohawk BriteHue Ultra Pink card stock is available online and at some retailers. See below for suggested online vendors.

Ultra Pink paper is used to distinguish the form from other forms in the patient's record; however, the form will be honored on any color paper. Faxed copies and photocopies are also valid POLST forms.

Suggested online vendors for Ultra Pink card stock:

Med-Pass - www.med-pass.com
(also carries pre-printed POLST forms on Ultra Pink card stock)

Boyd's Imaging Products - www.iboyds.com

Mohawk Paper Store - www.mohawkpaperstore.com

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2011)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If person has no pulse and is not breathing.*

When NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If person has pulse and/or is breathing.*

Check One

☐ **Comfort Measures Only** Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/ cardioversion as indicated. ***Transfer to hospital*** *if indicated. Includes intensive care.*

Additional Orders: _____

_____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ No artificial means of nutrition, including feeding tubes.

☐ Trial period of artificial nutrition, including feeding tubes.

☐ Long-term artificial nutrition, including feeding tubes.

Additional Orders: _____

_____

_____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____ available and reviewed →

☐ Advance Directive not available

☐ No Advance Directive

Health Care Agent if named in Advance Directive:

Name: _____

Phone: _____

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker

By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*		Date:
Address:	Daytime Phone Number:	Evening Phone Number:

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B
(Effective 4/1/2011)

First follow these orders, then contact physician. This is a Physician Order Sheet based on the person's current medical condition and wishes. Any section not completed implies full treatment for that section. A copy of the signed POLST form is legal and valid. POLST complements an Advance Directive and is not intended to replace that document. Everyone shall be treated with dignity and respect.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: *(optional)*

A — CARDIOPULMONARY RESUSCITATION (CPR): *If person has no pulse and is not breathing.*

When NOT in cardiopulmonary arrest, follow orders in Sections B and C.

Check One

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A **requires** selecting Full Treatment in Section B)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B — MEDICAL INTERVENTIONS: *If person has pulse and/or is breathing.*

Check One

☐ **Comfort Measures Only** Relieve pain and suffering through the use of medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ ***Transfer to hospital only*** *if comfort needs cannot be met in current location.*

☐ **Full Treatment** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/ cardioversion as indicated. ***Transfer to hospital*** *if indicated. Includes intensive care.*

Additional Orders: _____

_____

C — ARTIFICIALLY ADMINISTERED NUTRITION: *Offer food by mouth if feasible and desired.*

Check One

☐ No artificial means of nutrition, including feeding tubes. Additional Orders: _____

☐ Trial period of artificial nutrition, including feeding tubes. _____

☐ Long-term artificial nutrition, including feeding tubes. _____

D — INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

☐ Advance Directive dated _____ available and reviewed → Health Care Agent if named in Advance Directive:

☐ Advance Directive not available Name: _____

☐ No Advance Directive Phone: _____

Signature of Physician

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Print Physician Name:	Physician Phone Number:	Physician License Number:
Physician Signature: *(required)*		Date:

Signature of Patient or Legally Recognized Decisionmaker

By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: *(write self if patient)*
Signature: *(required)*		Date:
Address:	Daytime Phone Number:	Evening Phone Number:

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED