Advance Directive

Saint Luke's Health System

Health Care Directions

■ ***Take a copy of this with you whenever you go to the hospital*** ■

I, (Please print)_____, DOB_____
want everyone who cares for me to know what health care I want when I cannot let others know what I want.

I always expect to be given care and treatment for pain or discomfort even when such care might shorten my life, make me feel like not eating, slow down my breathing, or be habit-forming.

I want my doctor to try treatments that may get me back to an acceptable quality of life. By acceptable quality of life, I mean living in a way that lets me do the things that are important and necessary to me. Those things are:

_____

_____

Examples:
- *recognize family or friends*
- *make decisions*
- *communicate*
- *feed myself*
- *take care of myself*

I direct that no treatment be given just to keep me alive 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 there is no reasonable hope that I will regain a quality of life acceptable to me (as described above)

WHEN the above conditions exist: (check & initial)

	I Want	I Do Not Want
• Surgery	☐ _____	☐ _____
• Doing things to start my heart or breathing, if either stops (CPR)	☐ _____	☐ _____
• Medicine to treat infections (antibiotics)	☐ _____	☐ _____
• Artificial kidney machine (dialysis)	☐ _____	☐ _____
• Breathing machine (respirator, ventilator)	☐ _____	☐ _____
• Food or water given through a tube in the vein, nose or stomach (tube feedings)	☐ _____	☐ _____
• Chemotherapy (cancer treatments)	☐ _____	☐ _____
• Other Treatments:_____	☐ _____	☐ _____

If I mark "Yes" below, I understand that I will have given full legal consent to the donation of any of my organs or tissues upon my death for the purpose of transplantation, therapy, research, or education (RSMo. § 194.225 or K.S.A. § 65-3239 and K.S.A. § 65-3223). I realize additional tests and procedures may be required to determine whether I am a candidate for organ donation, and it may be necessary to maintain my body artificially until my organs can be removed**.** ☐ **Yes** ☐ **No** ☐ **Undecided**

My other directions include: _____

_____

Examples: • hospice care • death at home, if possible • specific directions regarding organ donation

Talk about this form and your ideas about your health care with the person you have chosen to make decisions for you, your doctor(s), family, friends, and clergy, and give each of them a completed copy. You may cancel or change this form at any time. You should review it every so often. Each time you review it, put your initials and the date here. _____

Be sure to sign this form on the reverse side of this page.

☐ The patient states that he/she has an Advance Directive; however, a copy is not available. The above Health Care Directions are an oral summary of the content of his/her Advance Directive.

Patient Signature:_____ Date:_____ Time:_____

RN Signature:_____ Date:_____ Time:_____

Patient Label:

Advance Directive

Saint Luke's Health System

Health Care Directions

■ ***Take a copy of this with you whenever you go to the hospital*** ■

It is important to choose someone to make health care decisions for you when you cannot. ***Tell the person (agent) you choose what you would want.*** *The person you choose has the same right as you do to make decisions and to make sure your wishes are honored. If you* ***DO NOT*** *choose someone to make decisions for you, write* ***NONE*** *on the line for the agent's name.*

I appoint the person named below to be my agent to make health care decisions for me when and only when I cannot make decisions or communicate what I want done. This is a Durable Power of Attorney for Health Care Decisions and the power of my agent shall not end if I become incapacitated or if there is uncertainty that I am dead. This revokes any prior Durable Power of Attorney for Health Care Decisions. My agent may not appoint anyone else to make decisions for me. I and my estate hold my agent and my caregivers harmless and protect them against any claim based upon following this Durable Power of Attorney for Health Care or my Health Care Directions. Any costs should be paid from my own resources. I grant to my agent full power to make all decisions for me about my health care, including the power to direct the withholding or withdrawal of life-prolonging treatment. In exercising this power, I expect my agent to be guided by my directions as stated in my Health Care Directions *(see reverse side).* My agent is also authorized to:

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

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

Agent's Name:_____ Phone:_____

Address:_____

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

First Alternate Agent	Second Alternate Agent
Name:_____	Name:_____
Address:_____	Address:_____
Phone:_____	Phone:_____

SIGN HERE for the *Durable Power of Attorney and/or Health Care Directions* forms. Many states require notarization. Please ask two (2) persons to witness your signature who are not related to you nor financially connected to you or your estate.

Signature:_____ Date:_____ Time:_____

Witness:_____ Date:_____ Time:_____

Witness:_____ Date:_____ Time:_____

Notarization:

On this _____ day 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:_____ Commission Expires:_____

Patient Label: