

Health Care Directives

Take a copy of this paper with you whenever you are hospitalized.

I, _____, _____, want the people who care for me to know
(print name) (date of birth)
what health care treatments I want when I cannot express my wishes to them.

I desire care and treatment for the relief of pain or discomfort.

Quality of life is very important to me. An acceptable quality of life for me would mean living in a way that lets me do the things that are important and necessary to me. For me, these include (check appropriate boxes):

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> recognizing family and friends | <input type="checkbox"/> taking care of myself | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> feeding myself | <input type="checkbox"/> communicating with others | _____ |
| <input type="checkbox"/> making my own decisions | <input type="checkbox"/> being able to leave the Health Center and return home | _____ |

End of life conditions are:

- 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

When I have one of the above end of life conditions, I request that the following treatments marked **DO** be started or continued. The treatments marked **DO NOT** should be discontinued or not used. Please initial the appropriate blank.

DO	DO NOT	
_____	_____	Surgery
_____	_____	CPR—doing things to restart my heart or breathing, if either stops
_____	_____	Dialysis—kidney machine
_____	_____	Ventilator or respirator—breathing machine
_____	_____	Artificially supplied nutrition and hydration—food or water—given through a tube in the vein, nose or stomach
_____	_____	Chemotherapy or radiation—cancer treatment
_____	_____	Blood transfusions
_____	_____	All other “life-prolonging” medical or surgical procedures that are merely intended to keep me alive without reasonable hope of significantly improving my condition

Other directions for my care are: _____

Examples: hospice care, death at home (if possible), directions regarding organ donation

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

Talk about your wishes and the information on this Health Care Directives form 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.

In the future, each time you review this form, put your initials and the date here: _____

For more information, call the Spiritual Care Department, 785-295-8280.



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Durable Power of Attorney for Health Care Decisions

I, _____, _____, appoint the person named
(print name) (date of birth)

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. 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 Directives (or other communication). 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 Health Center, 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, and execute any releases of other documents required to obtain such information;
- Move me into or out of any State or institution for the purpose of complying with my Health Care Directives or the decisions of my agent;
- Take legal action, if needed, to do what I have directed;
- Make decisions about autopsy, organ donation 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 one or more of the above things, draw a line through it and put your initials at the end of the line.

This is a Durable Power of Attorney for Health Care Decisions, and the power of my agent shall begin when I become incapacitated. 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 Directives. Such costs should be paid from my own resources.

Agent's Name _____ Phone _____ Work Phone _____

Address _____

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

First Alternate Agent Name _____ *Second Alternate Agent* Name _____

Address _____ Address _____

Phone _____ Phone _____

Document must be either witnessed or notarized.

Signature _____ Date _____

Witnesses: Two (2) people who are not related to you nor financially connected to you or your estate

Witness _____ Date _____ Witness _____ Date _____

Notary: This is recommended since many states require notarization.

On this _____ day of _____, in the year of 20____, I met the person who completed and signed 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 _____