



MR1005

Durable Health Care Power of Attorney and Health Care Treatment Instructions (Living Will)

PART I – DURABLE HEALTH CARE POWER OF ATTORNEY

I, _____ of _____ County, Pennsylvania, appoint the person named below to be my agent to make health and personal care decisions for me. Effective immediately, I authorize all health care providers and covered entities to disclose to my health care agent upon my agent’s request, any information, oral or written, regarding my physical or mental health. **Notwithstanding the foregoing, when and only when I lack sufficient capacity to understand, make or communicate a choice regarding a health or personal care decision as verified by my attending physician will the other provisions of this power of attorney become operative.** My agent may not delegate the authority to make decisions.

MY AGENT HAS ALL OF THE FOLLOWING POWERS (SUBJECT TO THE HEALTH CARE TREATMENT INSTRUCTIONS THAT FOLLOW IN PART II):

1. To authorize, withhold or withdraw medical care and surgical procedures;
2. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins;
3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care;
4. To hire and fire medical, social service and other support personnel responsible for my care;
5. To take any legal action necessary to do what I have directed.

APPOINTMENT OF AGENT

I appoint the following Agent: _____
 (name and relationship)

Address: _____

Telephone Numbers: Home _____ Work _____

You are not required to appoint a health care agent. If you do not wish to appoint a health care agent, write “None” in the above space. If you do not name a health care agent, health care providers will ask your family or an adult who knows your preferences and values for help in determining your wishes for treatment.

If my health care agent is not readily available or if my health care agent is my spouse and a divorce action is filed after the date of this document, I appoint the person or persons named below in the order named. *(It is helpful, but not required, to name alternative health care agents.)*

First Alternative Agent:	Second Alternative Agent:
_____ (Name and relationship)	_____ (Name and relationship)
Address: _____	Address: _____
Phone: Home _____ Work _____	Phone: Home _____ Work _____

PART II – HEALTHCARE TREATMENT INSTRUCTIONS (LIVING WILL)

The following healthcare treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make or communicate my treatment decisions:

END STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS

If I have an end-stage medical condition (which will result in my death despite the introduction or continuation of medical treatment) or if I am permanently unconscious and there is no realistic hope of significant recovery, all of the following apply:

1. I direct that I be given healthcare treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming;
2. I direct that all life-prolonging procedures be withheld or withdrawn;
3. I specifically **do not want** any of the following life-prolonging procedures: heart-lung resuscitation (CPR), mechanical ventilator (breathing machine), dialysis (kidney machine), surgery, chemotherapy, radiation treatment, antibiotics.

About completing your Durable Health Care Power of Attorney and/or Healthcare Treatment Instructions/Living Will

This form was developed by Legal Counsel for Saint Vincent Health Center to meet the requirements of Pennsylvania Law regarding *advance directives*. It is important to understand what the form is and what you are signing. These instructions will give you information on completing the form.

Part I: Durable Health Care Power of Attorney: if you decide to choose someone to be your agent, Part I will need to be completed.

1. It is your choice to name someone to be your health care agent to make health and personal decisions for you.
 - Read the information.
 - If you decide not to have a Durable Health Care Power of Attorney write “none” on the line for appointing and agent.
2. Fill in the name, relationship, address and phone numbers of the person you want to make decisions for you if, and when, you can no longer make them for yourself. Think of having an alternative agent(s).

Part II: Healthcare Treatment Instructions (Living Will): if you decide to have your wishes in writing, Part II needs to be completed.

1. You understand that this will be used to direct your care only if you lack the capacity to understand, make or communicate treatment decisions and you have an end-stage medical condition or are permanently unconscious.
2. The following explanations may help you understand the medical treatments listed on the form.
 - Cardiopulmonary resuscitation (CPR) is done to restore normal heart beat and breathing after one or the other (or both have stopped). During CPR, oxygen is being given to the patient by putting a mask over the patient’s face and using a bag to get oxygen into the patient’s lungs. Sometimes the patient is intubated, that is, a tube is inserted into the lungs and oxygen is given directly. When the heart is stopped and the person has no pulse, the chest area over the heart is compressed to try to restore heart rhythm and deliver blood throughout the body. Various medications may also be given during CPR.
 - Mechanical ventilator (breathing machine) is the use of a machine to breathe for the patient.
 - Dialysis (kidney machine) is the use of a machine to take waste products out of the blood when a patient’s kidneys no longer function.
 - Antibiotics are drugs used to fight infections.
 - Tube feeding is the use of a tube placed in the nose, mouth, stomach or intestines to give nutrition and water to a patient not able to eat or drink normally.

continued on the back of page 2



MR1005

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Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery. (Initial only one statement.)

TUBE FEEDINGS

OR

NO TUBE FEEDINGS

_____ I **want** tube feedings to be given.

_____ I **do not want** tube feedings to be given.

SEVERE BRAIN DAMAGE OR BRAIN DISEASE

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome, and I want my healthcare providers and agent to treat any intervening life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated in this Durable Health Care Power of Attorney and Living Will.

Initials _____ I agree

OR Initials _____ I disagree

GOALS (OPTIONAL)

If I have an end-stage medical condition or other extreme irreversible medical condition, my goals in making medical decisions are as follows (insert your personal priorities such as comfort care, preservation of mental functions, etc.)

HEALTH CARE AGENT’S USE OF INSTRUCTIONS (Initial one option only.)

_____ My health care agent must follow these instructions.

OR

_____ These instructions are only guidance. My health care agent shall have final say and may override any of my instructions.

If I did not appoint a health care agent, these instructions shall be followed.

LEGAL PROTECTION

On behalf of myself, my executors and heirs I hold my health care agent and my health care providers harmless, and release and indemnify them against any claim for their good faith actions in recognizing my health care agent’s authority or for following my treatment instructions.

ORGAN DONATION (Initial one option only.)

_____ I consent to donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education. (Insert any limitations you desire on donation of specific organs or tissues or uses for donation of organs and tissues: _____)

OR

_____ I do not consent to donate my organs or tissues at the time of my death.

SIGNATURE

Having carefully read this document, I have signed it this _____ day of _____ 20_____, revoking all previous health care powers of attorney and health care treatment instructions.

(SIGN FULL NAME HERE FOR HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE TREATMENT INSTRUCTIONS)

WITNESS: _____ **WITNESS:** _____

Two witnesses of at least 18 years of age are required in Pennsylvania and should witness your signature in each other’s presence. (It is preferable if the witnesses are not your heirs or your creditors, nor employed by any of your health care providers.)

3. Initial your choice about tube feedings.
4. Initial your choice on considering severe brain damage or brain disease as an end-stage medical condition.
5. You have an option to document your goals.
6. Initial your choice if you want your health care agent to follow your instructions or to use them as a guidance.
7. Initial your choice on organ donation.

In order for the Durable Health Care Power of Attorney and/or Health Care Treatment Instructions/ Living Will to be valid you **must date and sign the form and have your signature witnessed by two people who are at least 18 years old.** If you complete the form while you are a patient at Saint Vincent Health Center, and don't have available witnesses (friends or family), the chaplain or a nursing supervisor may be a witness. According to policy, they are the only associates of the hospital who can do so.

When you have your form completed your nurse will make a copy of it and place it in your medical record. The original will be returned to you. Copies of the form should be given to your physician, nursing home, person you appointed as Durable Health Care Power of Attorney, family members or other individuals you want to have the form.

Each time you enter a health care facility, you will be asked if you have advance directives. It's the law!



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NOTARIZATION (OPTIONAL)

(Notarization of document is not required in Pennsylvania, but if the document is both witnessed and notarized, it is more likely to be honored in some other states.)

On this _____ day of _____, 20____, before me personally appeared the afroresaid declarant and principal, 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 hand and affixed my official seal in the County of _____, State of _____, the day and year first above written.

My Commission Expires

Notary Public