advance directive healthcare form

_____

(print full name here)

Please place the completed document on the front of your refrigerator, or any location where an emergency responder might easily see it.

Ivinson MEMORIAL HOSPITAL

AN AFFILIATE OF UCHealth

Instructions

Part 1 of this form is a power of attorney for health care. This 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. Unless related to you, your agent may not be an owner, operator or employee of a residential or community care facility at which you are receiving care.

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, programs of medication and orders not to resuscitate; and

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

Part 2 of this form lets you give specific instructions about any aspect of your health care. 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 provided for you to add to the choices you have made or for you to write out any additional wishes. This form also lets you express an intention to donate your bodily organs and tissues following your death. Lastly, 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. This form must either be signed before a notary public or, in the alternative, be witnessed by two (2) witnesses. 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

(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)

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 alternative agent)

_____
(address) (city) (state) (zip code)

_____
(home phone) (work phone)

(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:

_____
_____
_____

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I lack the capacity to make my own health care decisions.

(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.

Part 2 - Advance Health Care Directive

Please strike any wording that you do not want.

I, _____, being of sound mind and at least 18 years of age, declare that:

(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 initialed below:

[_____] (a) Choice NOT To Prolong Life.

I do not want my life to be prolonged if (i) I have an incurable and irreversible condition that will result in my death within a relatively short period of time, (ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or (iii) 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) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (1) unless I initial the following box.

[_____] (a) Artificial nutrition must be provided regardless of my condition and regardless of the choice I have made in paragraph **(1)**.

(3) 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:

_____

_____

_____

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

_____

_____

_____

(5) DONATION OF ORGANS AT DEATH (OPTIONAL): Upon my death (initial applicable box):

[_____] (a) I give my body, OR

[_____] (b) I give any needed organs, tissues or parts, OR

Part 2 - Advance Health Care Directive

[_____] (c) I give the following organs, tissues or parts only:

_____

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

(i) Any purpose authorized by law;
(ii) Transplantation;
(iii) Therapy;
(iv) Research;
(v) Medical education.

(6) PRIMARY PHYSICIAN: I designate the following physician as my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

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

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

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

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

_____ _____
(print name) (sign name) (date)

_____
(address) (city) (state) (zip code)

_____
(phone)

Part 2 - Advance Health Care Directive

(9) SIGNATURES OF WITNESSES OR NOTARY PUBLIC: I declare under penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this document in my presence, that the principal appears to be of sound mind and under no duress, fraud or undue influence.

According to Wyoming State Statute 35-22-403 (b), witnesses shall **not** be any of the following: a person appointed as agent by this advance directive, a treating health care provider, an employee of a treating 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, nor an employee of an operator of a residential care facility.

First Witness

_____

(print witness' name) (address) (city) (state) (zip code)

_____

(signature of witness) (date)

Second Witness

_____

(print witness' name) (address) (city) (state) (zip code)

_____

(signature of witness) (date)

Notary Public (in lieu of witnesses)

STATE OF WYOMING)
) S.S.
COUNTY OF _____)

Subscribed and sworn to and acknowledged before me by _____, the Principal, this _____ day of _____, 20____.

My commission expires: _____.

_____

Notary Public Signature

mission | Dedicated partners providing integrated and innovative healthcare.

vision | Exceptional care.