ADVANCE CARE PLANNING

Name _____

Address _____

Birthdate _____ Phone _____ Date _____

We recommend you give copies of this to your

Medical decision-makers

1. _____
2. _____

Physician(s)

1. _____
2. _____
3. _____

Additional copies have been given to:

1. _____
2. _____
3. _____
4. _____
5. _____

IN CASE OF EMERGENCY

I have an Advanced Directive:
Name_____
Address_____
Phone_____
My Advanced Directive is filed at:
Location_____
Address_____
Phone_____
My Agent Under My Durable Power of Attorney is:
Name_____
Address_____
Phone (H)_____ (W)_____
Date_____

INTENTIONALLY LEFT BLANK

IN CASE OF EMERGENCY

My Alternative Agent Under My Durable Power of Attorney is:
Name_____
Address_____
Phone (H)_____ (W)_____

My health care provider is:
Name_____
Address_____
Phone_____

Part 1: Tell Us about What Matters Most to You

Here is how we make medical decisions in our family:
Examples: I make the decision myself, my entire family has to agree on major decisions about me, my daughter who is a nurse makes the decisions etc.

_____

_____

_____

_____

_____

Here is what matters most to me:
Examples: Being at home, doing gardening, traveling, going to church, playing with my grandchildren

_____

_____

_____

_____

_____

Here are my important future life milestones:
Examples: my 10th wedding anniversary, buying a home, birth of my granddaughter

1. _____

2. _____

3. _____

4. _____

Here is how we prefer to handle bad news in my family:
Examples: We talk openly about it, we shield the children from it, we do not like to talk about it, we do not tell the patient.

_____

_____

_____

_____

Full legal name _____

Please write down your care choices

	initial your care choice		
Treatment	**I refuse**	**I accept**	**Specific Instructions (example: for how long)**
CPR (Cardiopulmonary Resuscitation): Using electric shocks, chest compressions and a breathing tube to try to make the heart beat again and restore breathing after it has stopped.	_____	_____	
Breathing machine support (ventilator)	_____	_____	
Kidney dialysis	_____	_____	
Blood transfusions	_____	_____	
Artificial food and fluids placed directly into my vein or stomach to give me liquid food.	_____	_____	

Full legal name _____

Please allow natural death

if I become	Do not connect me to life support machines; disconnect me from life support machines if already in use.		
	Initial One		Specific Instructions
Permanently Unconscious: I am in a coma and not aware of people or my surroundings and my doctors determine that I am unlikely to ever wake up from the coma.	____ Yes	____ No	
Permanently Confused: • I cannot and will not be able to recognize my loved ones. • I am not able to make any health decisions.	____ Yes	____ No	
Dependent on others for all my care: I am no longer able to talk or communicate clearly or move by myself. Others have to feed, toilet, bathe, and dress me everyday.	____ Yes	____ No	
End stage illness: I have an illness that has reached its final stages in spite of full treatment.	____ Yes	____ No	

Please write other detailed instructions here:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Full legal name _____

Here is what I DO WANT at the end of my life: (initial all that apply)

_____ I want to be pain free

_____ I want you to allow me to die gently and naturally

_____ I want to die at home

_____ I want hospice care

_____ Other: Please use the space below to give detailed instructions to your doctors

_____

_____

_____

_____

_____

Here is where I want to spend the last days of my life: (initial one)

_____ In the hospital

_____ At home or in a home-like setting

_____ Other _____

If my pain and distress are difficult to control, please sedate me (make me sleep with sleep medicines) even if this means that I may not live as long. (initial one)

_____ Yes

_____ No

Here is what I want to do when my family wants you to do something different than what I want for myself: (initial one)

_____ I am asking you to show them this letter and guide my family to follow my wishes.

_____ I want you to override my wishes as my family knows best.

After a person passes away, their organs and tissues (eyes, kidneys, liver, heart, skin etc.) can be donated to help other people who are ill.

Please initial one of the following:

_____ I will donate any of my organs and tissues

_____ I will donate the following organs and tissues only

_____

_____

_____ I do NOT want to donate my organs or tissues

_____ I do NOT want to decide now. My agent can decide later.

Please initial below to give permission:

_____ My agent can make funeral arrangements when needed

Full legal name _____

Part 2: Who makes decisions for you when you cannot

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Here is who I want making medical decisions for me when I am not able to make my own decisions:

Primary Agent

_____ _____
Name Relationship

_____
Address

_____ _____ _____
City State Zip

_____
Phone number(s)

If primary agent is unable or unavailable to make decision at the time then my secondary agent is:

Secondary Agent

_____ _____
Name Relationship

_____
Address

_____ _____ _____
City State Zip

_____
Phone number(s)

PLEASE INITIAL ONE: I want my agent to make health decisions for me:

_____ **Starting right now**

(OR)

_____ **When I am not able to make decisions by myself**

Full legal name _____

Dated this _____ day of _____, 2 _____.

Full legal name _____

Signed: _____
(Signature)

_____
Address City State Zip

Witness cannot be a decision maker listed on page 2.

_____
(Witness Signature)

_____
Printed name Relationship

_____
Address City State Zip

_____
(Witness Signature)

_____
Printed name Relationship

_____
Address City State Zip

Notary (required if leaving state of Montana)

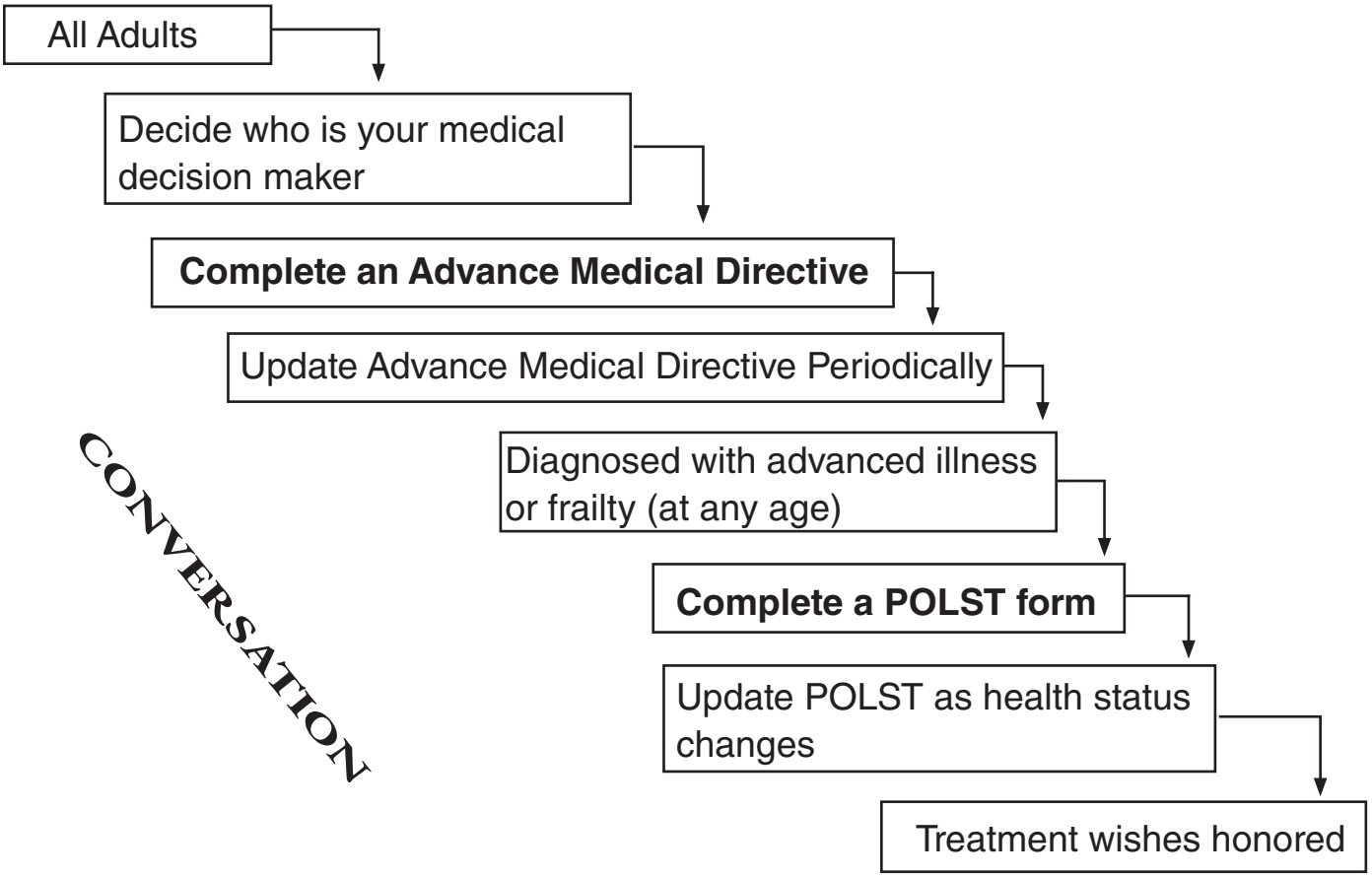
Notarization: This document was acknowledged before me on _____(date) by _____(name of Principal), known to me to be the person whose name is subscribed to the within instrument and acknowledged to make that [ ] executed the same. IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year first-above written.

Advance Medical Directive Glossary

Advance Medical Directive – A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of an Advance Medical Directive differently.

Polst – (Physician Orders for Life Sustaining Treatment) https://POLST.org
Polst forms are portable medical orders that travel with the patient. A POLST form is for when you become seriously ill or frail, toward the end of life. Ask your provider for a POLST form if needed.

How an Advance Medical Directive and POLST form work together



Medical decision-maker (power of attorney for health care) – The person you name in an Advance Medical Directive or as permitted under state law to make health care decisions on your behalf when you can no longer make medical decisons. An Advance Medical Directive may be called a health care proxy, durable power of attorney for health care, or appoinmtment of a health care agent. The person appointed may be called a health care agent, surrogate, attorney-in-factor or proxy.

Power of attorney (financial) – A legal document allowing one person to act in a legal matter on another's behalf regarding financial or real estate transactions.

Surrogate decision-making – Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatment for a patient who has lost decision-making capacity and did not prepare an Advance Medical Directive. A majority of states have passed statues that permit surrogate decision-making for patients without Advance Medical Directives.

Hospice – Hospice care is provided to a patient who has a chronic and usually terminal illness with a usual life expectancy of 6 months or less. Hospice care is provided by an interdisciplinary team (physician, nursing, social work) to give patients and families an extra layer of support and help to manage distressing and painful symptoms. Patients on hospice are not seeking curative treatment and the focus is on comfort and quality of life at the end of life.

Palliative care – A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, and controlling pain and symptoms. Care can be provided even if a patient wants curative or life-prolonging treatment.

Artificial nutrition and hydration – Artificial nutrition and hydration supplements replace ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

Brain death – The irreversible loss of all brain function. Most states legally define death to include brain death.

Capacity – In relation to end-of-life decision-making, a patient has medical decision-making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

Cardiopulmonary resuscitation – Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may include mouth-to-mouth breathing and pressing on the chest.

Comfort care – Treatment, including prescription medications, given to the patient to alleviate pain, or other physical/emotional distress. Treatment to prolong life is usually not provided.

Intubation – Intubation is the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing and to connect with a ventilator.

Life-sustaining or life-prolonging treatment – Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatment). Life-prolonging treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis and other treatments.

Mechanical ventilation – Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth an down into the windpipe (or trachea).

Respiratory arrest – An event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

Ventilator – A ventilator, also known as a respirator, is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

Withholding or withdrawing treatment – Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.

Advance Care Planning Tools
Available on-line

PREPARE for Your Care™. PREPARE is an online resource in English and Spanish that helps people learn about and prepare for medical decision making. This evidenced-based tool features video stories and examples and guides people as they explore their wishes and learn how to discuss them with family, friends, and medical providers. The result is a 'Summary of My Wishes' document which can be shared with family and friends, caregivers and medical providers. PREPARE also offers easy-to-read, legally-binding advance directives for all 50 states in English and Spanish. www.prepareforyourcare.org.

The Conversation Project, an initiative begun in 2010 dedicated to helping people talk about their wishes for end-of-life care. Their Conversation Starter Kit is a useful tool to help you have the conversation with a family member, friend, or other loved one about your – or their – wishes regarding end-of-life care. It is available in several languages. www.theconversationproject.org.

Consumer's Tool Kit for Health Care Advance Planning, by the American Bar Association Commission on Law and Aging is available for free download. http://ambar.org/agingtoolkit.

The Stanford Letter Project. This free website offers three tools available in several languages and formats with real patient videos, at http://med.stanford.edu/letter.

- The "What-Matters-Most" letter template. Simple letter template any one can use to write to their doctor about their care choices and preference
- The "Who-Matters-Most" letter template. Simple letter template any one can use to complete the seven tasks of life review and write to their loved ones.
- The "I-Matter-Too" tool. Allows patients to identify their life goals from six common choices

CaringInfo, a program of the National Hospice and Palliative Care Organization, provides free resources to help people make decisions about end-of-life care and services before a crisis. www.caringinfo.org

The *Go Wish* Game, a card game for sorting out values related to end-of-life decision-making, created by the Coda Alliance. The cards help you find words to talk with family or friends about what is important if you were to be living a life that may be shortened by serious illness. Although there is a charge for ordering the card decks, Go Wish can be played online for free. www.gowish.org

MyDirectives.com. MyDirectives is a free web-based service that walks you through the process of creating an "advance digital directive" which can be electronically signed. Includes a smartphone app. The directive is encrypted and stored in their secure database, available to you and your medical treatment providers 24/7. https://mydirectives.com

Advance Care Planning Decisions, produces short, evidence-based videos exclusively for health care providers to assist patients and providers in decision-making in clinical settings. A limited number of videos for consumers are available free in multiple languages. Topics include: The Conversation; POLST; What is Palliative Care; Talking to Your Doctor; and A Patient Checklist. https://acpdecisions.org/patients.

Compassion and Choices - Tools to Plan for your Care. This web page offers a multitude of useful tools aimed at ensuring you get the care you want. https://www.compassionandchoices.org/eolc-tools/

Thinking Ahead: My Way, My Choice, My Life at the End. This workbook and video were created by California advocates with developmental disabilities and distributed by the Coalition for Compassionate Care of California. However, it is a good tool for anyone who wants a simple, easy-to-follow workbook. http://coalitionccc.org/tools-resources/people-with-developmental-disabilities.

Five Wishes. An advance care planning program of Aging with Dignity. Easy to use resources include the Five Wishes advance directive (available in 29 languages and Braille), conversation guides, clinician guides and training programs. Five wishes addresses emotional, spiritual and personal aspects of care, along with appointing an agent and providing instructions. A free discussion starter is available. Other resources are available for a small fee. www.fivewishes.org.

Guides for health care agents

How to Choose a Health Care Proxy & How to Be a Health Care Proxy, by the Conversation Project. https://theconversationproject.org/wp-content/uploads/2017/03/ConversationProject-ProxyKit-English.pdf

Making Decisions for Someone Else: A How-To Guide, published by the ABA Commission on Law and Aging, this guide is for anyone serving in the role of health care decision maker for someone else: http://ambar.org/agingproxyguide.

Guides for talking to one's physician

How to Talk to Your Doctor: Discussing End-of-life Care with Your Doctor, Nurse, or Other Health Care Provider. The Conversation Project.
https://theconversationproject.org/wp-content/uploads/2017/02/ConversationProject-TalkToYourDr-English.pdf

NIH Resources for "Talking to your Doctor," National Institutes of Health, https://www.nih.gov/institutes-nih/nih-office-director/office-communications-public-liaison/clearcommunication/talking-your-doctor

General end-of-life care references *(some require purchase)*

END OF LIFE: What Are Palliative Care and Hospice Care? An online publication by the National Institutes on Aging (NIA) that explains palliative care and hospice options, with links to free related NIA articles. www.nia.nih.gov/health/what-are-palliative-care-and-hospice-care.

Handbook for Mortals: Guidance for People Facing Serious Illness by Joanne Lynn, Joan Harrold, and Janice Lynch Schuster (2nd Ed., Oxford Univ. Press, 2011). A comprehensive and readable 320-page guide to dealing with serious, eventually fatal illness. Available for purchase from Amazon or in book stores. Individual chapters are downloadable for free at: http://growthhouse.org/mortals/mor0.html.

Hard Choices for Loving People: CPR, Artificial Feeding, Comfort Measures Only and the Elderly Patient by Hank Dunn (A&A Publishers, 2016) Available for purchase at: www.hankdunn.com. A concise and helpful 80-page booklet on end-of-life decisions concerning resuscitation, food and fluids, hospitalization, and cure versus comfort care.

Fidelity, Wisdom and Love: Patients and Proxies in Partnership by Joseph J. Fins and Barbara S. Maltby (Weill Medical College of Cornell University, March, 2003). A workbook and video designed as a step-by-step guide that provides everything you need to know about choosing, appointing, or being a healthcare proxy. It contains four medical scenarios designed to foster dialogue between patients and proxies in order to define possible choices for care and to increase patient/proxy understanding and knowledge. Available for purchase from Amazon.com.