Durable Power of Attorney for Healthcare Decisions

Federal and State law requires that we provide you with this information.

Name:____ DOB:____________________

The Durable Power of Attorney (DPOA) for Healthcare Decisions allows you to appoint someone else to make healthcare decisions on your behalf if you are unable to make decisions or communicate your wishes. The person you appoint is called your agent.

- Your healthcare agent should be someone who understands your goals and values and someone whom you trust to carry out your wishes.
- You may choose a family member or friend who is at least 18 years old.
- Your agent cannot be a doctor, an employee of a doctor or an owner, operator or employee of a healthcare facility in which you live, unless you are related.
- Make sure that the person is willing to act as your agent and talk candidly about your end-of-life wishes so there are no misunderstandings.
- Your agent may make healthcare decisions for you only if you are physically or mentally unable to do so yourself.

AGENT'S POWERS

By completing this durable power of attorney, I authorize my agent to make all decisions for me regarding my healthcare. This includes the power to withdraw any type of healthcare, treatment or procedure, even if I may die in the process. I expect my agent to follow my healthcare choice directive. My agent has the power to:

- Consent, refuse or withdraw consent to artificially-supplied nutrition and hydration.
- Make all necessary arrangements for healthcare on my behalf. This includes admitting me to any hospital, psychiatric treatment facility, hospice, nursing home or other healthcare facility.
- Request, receive and review my medical and hospital records.
- Carry out my wishes regarding autopsy and organ donation and decide what should be done with my body.

My agent shall not be responsible for any costs associated with my care.

This is a Durable Power of Attorney and the authority of my attorney in fact, when effective, shall not terminate or be void or voidable if I am or become disabled or incapacitated or in the event of later uncertainty as to whether I am dead or alive.

Signature:____ Date:____________________

Changes to this DPOA for Healthcare Decisions:

Your DPOA for Healthcare Decisions stays in effect until you die unless you change it or revoke it. A change to your DPOA for Healthcare Decisions requires revocation of this document.

Durable Power of Attorney for Healthcare Decisions

If I, (print name) ____ DOB:____________________

of (address) ____

am unable to make healthcare decisions myself, I appoint the person named below to be my healthcare agent to make any and all healthcare decisions for me, including accepting or refusing any treatment, service or procedure to diagnose or treat my physical or mental condition. It includes decisions to provide, withhold or withdraw life-sustaining treatment and other rights as indicated within of this document. I expect my healthcare agent to make decisions on my behalf in accordance with my wishes. In the event my wishes are not clear, or if a situation arises that I did not anticipate, my healthcare agent is authorized to make healthcare decisions in my best interest.

PRIMARY AGENT:

Name:____ Phone:____________________

Address:____

ALTERNATE AGENT(S) *(optional)*: If the Primary Agent named above is unable, unwilling, or unavailable to act as my healthcare agent/representative, I appoint the following person(s) as my alternate healthcare agent(s)/representative(s):

First Alternate Agent:

Name:____ Phone:____________________

Address:____

Second Alternate Agent:

Name:____ Phone:____________________

Address:____

Initial, if applicable	According to Missouri law, this durable power of attorney becomes effective when two (2) physicians certify you are incapacitated and unable to make and communicate healthcare choices. You may choose to have one (1) physician determine whether you are incapacitated. If you wish to allow one (1) physician, instead of two (2), determine you are incapacitated, initial this box.

My Signature:____ Date:____________________

<u>NOTARIZATION</u>*:* On this ______ day of __________________, 20____, 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 official seal in the County of _________________, State of Missouri, on the date written above.

Notary Public Signature:________________________________

My commission expires:________________________________

REVOCATION: I revoke this Durable Power of Attorney:______________________________ ______________
SIGNATURE DATE

WITNESS:	WITNESS:
Signature:____________________ Date:__________	Signature:____________________ Date:__________
Printed Name:____________________________	Printed Name:____________________________

Medical Healthcare Directive Including Living Will

Federal and State law requires that we provide you with this information.

Name:____ DOB:__________________________

Your medical healthcare directive allows you to provide clear and convincing proof of whether you want your life lengthened by medical treatment. When you become unable to make decisions or communicate your wishes, your doctor and/or your agent will make decisions based on what you have expressed in this Medical Healthcare Directive.

If you have named an agent (Durable Power of Attorney for Healthcare Decisions), and if this person is able and willing to exercise this authority, then only this person has the legal authority to make healthcare decisions for you. Tell your family who you have chosen as your agent. Your agent may wish to talk with your family before making decisions.

Healthcare providers and your agent should follow the directions given in this advance directive. An exception is if your request would require a healthcare provider to break the law, or if the physician believes the medical care would be futile. A provider who does not want to follow your directive should help you transfer to a facility where your advance directive will be honored.

Changes to this Advance Directive:
Your advance directive stays in effect until you die unless you change it or revoke it. A change to your directive requires revocation of this document.

Quality of Life *(optional)*

I want to be kept alive if there is reasonable hope of returning to a quality of life acceptable to me. By acceptable quality of life, I mean living in a way that lets me do the things that are important to me. These things are (initial each selection important to you):

Initial selections		*Initial selections*	
☐	Recognize my family and loved ones	☐	Make decisions
☐	Communicate	☐	Take care of myself
☐	Other:	☐	Other:

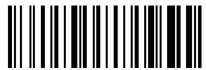
Help for Discussing End-of-Life Issues

Keep in mind that even though your wishes are in writing, it may be difficult for others to understand them. That's why it is so critical to talk with your family. Having this conversation will lessen the pain, doubt and anxiety for your loved ones as you near death. While there is no right way or right time to start a conversation about the end-of-life with your family, these tips may help you get started:

1. Describe someone else's experience.
2. Say your attorney urged you to have the conversation.
3. Write a letter or make a video describing your wishes. Have your family review it before you talk.

Your family may resist have the conversation – it's often difficult to contemplate the loss of a loved one. Stand your ground about the importance of talking about dying and bring up the consequences of putting off the conversation. It also may help to have someone be your spokesperson and lead the conversation. In the end, you all will have greater peace of mind.

I have reviewed this information. Patient initials:_______ Date:____________________



Medical Healthcare Directive Including Living Will

I, (print name) ______________________________ DOB:______________

of (address) ______________________________

hereby give these advance instructions to my doctors or healthcare agent on how I want to be treated by my doctors and other healthcare providers when I can no longer make treatment decisions myself. I make this directive to provide clear and convincing proof of my wishes and instructions about my healthcare and treatment. In the event my doctor believes medical treatment will lead to my recovery, I want to have the treatment. I also want to have care and treatment for pain or discomfort even if this treatment might shorten my life, affect my appetite, slow down my breathing or be habit-forming.

Treatment

If I have a terminal illness or condition, or if I am persistently unconscious and there is no reasonable hope I will recover, I direct all of the life-prolonging procedures I have initialed below to be withheld or withdrawn.

Initial selections		*Initial selections*	
☐	Surgery or other invasive procedures	☐	Mechanical ventilator (respirator)
☐	Cardiopulmonary resuscitation (CPR) to restart my heart or breathing	☐	Artificially-supplied nutrition and hydration (including tube feeding)
☐	Antibiotics	☐	Chemotherapy
☐	Dialysis	☐	Radiation therapy

☐ All other “life-prolonging” medical treatments or surgeries that are merely intended to keep me alive without reasonable hope of making me better or curing my illness or injury.

Organ/Tissue Donation

I direct the donation of my organs or tissue. I realize my body may need to be maintained artificially after my death until my organs can be removed.

Initial appropriate box: ☐ I want to donate my organs & tissue ☐ I do not want to donate my organs & tissue ☐ I will decide later

My Signature:______________________________ Date:______________

Witness Signature:______________	Witness Signature:______________
Date:______________	Date:______________
Printed Name:______________	Printed Name:______________
Address:______________	Address:______________
______________	______________

REVOCATION: I revoke this Healthcare Advance Directive:______________ ______________

SIGNATURE DATE

WITNESS:	WITNESS:
Signature:______________ Date:__________	Signature:______________ Date:__________
Printed Name:______________	Printed Name:______________