CHI St. Alexius Health

HEALTH CARE DIRECTIVE

You may choose to do all or any one of the following

A. Appointment of Health Care Agent

I, ____, trust and appoint_____________________________ as my health care agent. As my health care agent, this person can make health care decisions for me if I am unable to make and communicate them for myself or upon my request.
If my health care agent is not reasonably available, I trust and appoint ________________________________
____ to be my alternate health care agent.

B. Health Care Instructions

Medical treatments may be withheld or withdrawn if they do not offer a reasonable hope or benefit to me or are excessively burdensome. I do, however, ask that treatment be administered that will provide me with maximum comfort and freedom from pain.

(Initial in front of any of the choices below)

If I am in an unconsciousness state and there **is** hope for recovery and quality of life, I desire:
______ Medical care appropriate to my condition including ventilation as long as my condition is improving

If I am terminally ill, or in a persistent vegetative state or if death is imminent and there is **no** hope for recovery, I desire:
_______ Comfort measures only (No ventilation, No hydration, No nutrition)
OR
_______ Ventilation
_______ Hydration
_______ Nutrition

Statement of other desires, goals, special provisions regarding my healthcare, life-prolonging care, treatment, services, and procedures: ____
____
____

C. Organ or Tissue Donation

I would like to be an organ donor at the time of my death. I have told my family my decision and ask my family to honor my wishes. Initial only one of the following statements:
_______ Any needed organ or tissue
_______ Only the following organs and tissue____

Date and Signature of Principal

I have read a written explanation of the nature and effect of an appointment of health care agent that is attached to my health care directive. (Located on page 4)
This document revokes any prior durable power of attorney for health care.

I sign this Health Care Directive on _______________________at__________________________ , ________
(Date) (City) (State)

____ DOB: ____________________________
(Your signature here)

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NOTARY PUBLIC OR STATEMENT OF WITNESSES

This document must be (1) notarized or (2) witnessed by two qualified adult witnesses. The person notarizing this document may be an employee of a health care or long-term care provider providing your care. **At least one witness to the execution of the document must not be a health care or long term care provider providing you with direct care or an employee of the healthcare or long term care provider.** None of the following may be used as a notary or witness:

1. A person you designate as your agent or alternate agent
2. Your spouse
3. A person related to you by blood, marriage, or adoption
4. A person entitled to inherit any part of your estate upon your death: or
5. A person who has, at the time of executing this document, any claim against your estate

OPTION 1: Notary Public

In my presence on ____________________ (Date) ____________________________________ (Name of declarant)

acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.

____

Signature of Notary Public (Notary Seal)

County of _________________________, State of _________

My commission expires__________________, 20_________

OPTION 2: Two Witnesses

Witness One:

1. In my presence on ______________ (Date) _________________________ (Declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.
2. I am at least eighteen years of age.
3. If I am a health care provider or an employee of a health care provider giving direct care to the declarant, I must initial here: __________

I certify that the information in (1) through (3) is correct.

____ ____

(Signature of Witness One) (Address)

Witness Two:

1. In my presence on ______________ (Date) _________________________ (Declarant) acknowledged the declarant's signature on this document or acknowledged that the declarant directed the person signing this document to sign on the declarant's behalf.
2. I am at least eighteen years of age.
3. If I am a health care provide or an employee of a health care provider giving direct care to the declarant, I must initial here: __________

I certify that the information in (1) through (3) is correct.

____ ____

(Signature of Witness Two) (Address)

ACCEPTANCE OF APPOINTMENT OF HEALTH CARE AGENT

I accept this appointment and agree to serve as agent for health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment.

I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapacitated.

I understand that I must act in good faith in exercising my authority under this power of attorney. I understand that the principal may revoke this appointment at any time in any manner.

If I choose to withdraw during the time the principal is competent, I must notify the principal of my decision. If I choose to withdraw when the principal is not able to make health care decisions, I must notify the principal's physician.

______________________________	______________________________
(Signature of Agent) (Date)	(Signature of Alternate Agent) (Date)
Address: ______________________	______________________________
City, State: ___________________	______________________________
Phone number: _________________	______________________________
Relationship: __________________	______________________________

Please review the written explanation of the nature and effect of an appointment of a heath care agent in your Health Care Directive who would make health care decisions for you if you were not able to make health care decisions for yourself. This is an important legal document that is authorized by the general laws of this state. Before executing this document, you should know these important facts. This information is available on page 4.

This is a written explanation of the nature and effect of an appointment of a health care agent in my Health Care Directive who would make health care decisions for me if I were not able to make health care decisions for myself. This is an important legal document that is authorized by the general laws of this state. Before executing this document, you would know these important facts.

➤ You must be of at least eighteen years of age for this document to be legally valid and binding.

➤ This document gives the person you designate as your agent (the attorney in fact) the power to make health care decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

➤ Except as you otherwise specify in this document, this document gives your agent the power to consent to the doctor not giving treatment or stopping treatment necessary to keep you alive.

➤ Notwithstanding this document, you have the right to make medical and health care decisions for yourself as long as you can give informed consent with respect to the particular decision.

➤ This document gives your agent the authority to request, consent to, refuse to consent to, or to withdraw consent for any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition if you are unable to do so yourself. This power is subject to any statement of your desires and any limitation that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make health care decisions for you if your agent authorizes anything that is illegal; acts contrary to your known desires; or where your desires are not known; or does anything that is clearly contrary to your best interest.

➤ Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death.

➤ You have the right to revoke the authority of your agent by notifying your agent or treating doctor, hospital, or other health care provider orally or in writing of this revocation.

➤ Your agent has the right to examine your medical records and to consent to their disclosure unless you limit the right in this document.

➤ This document revokes any prior durable power of attorney for health care.

➤ You should carefully read and follow the notarizing or witnessing procedure described at the end of this form. This document will not be valid unless you comply with the notarizing witnessing procedure.

➤ If there is anything in this document that you do not understand, you should ask a social worker, clergy, or lawyer to explain it to you.

➤ You should keep the original document. Copies should be given to the hospital, your health care provider, clinic, family member/health care agent.

➤ Form Made Fillable by eForms.