# ADVANCE CARE PLANNING


St. Peter's Health

953-500-S-1 (2/2020)

# ADVANCE CARE PLAN (page 1 of 6)
## Combination living will and Power of attorney for health care

***Language interpretation and sign language services are available free of charge.***

Please Print with Blue or Black Ink. **(Checked boxes indicate selection)**

Full Name:_____Date of Birth:_____

Current Address:_____

City:_____State:_____Zip Code:_____

Home Phone:_____Cell Phone:_____

These directions apply only in situations when I am not able to make or communicate my health care choices directly. Put an X through any sections you are not completing at this time.

### Terminal Conditions (Living Will)

I provide these directions in accordance with the Montana Rights of the Terminally Ill Act. These are my wishes for the kind of treatment I want if I cannot communicate or make my own decisions. These directions are only valid if both of the following two conditions exist:

- **I have a terminal condition, and**
- **In the opinion of my attending physician, I will die in a relatively short time without life sustaining treatment that only prolongs the dying process**.

I authorize my Representative/agent/POA, if I have appointed one, to make the decision to provide, withhold, or withdraw any health care treatment.

### General Treatment Directions

Check the boxes that express your wishes:

☐ I provide no directions at this time.

❑ I direct my attending physician to withdraw or withhold treatment that merely prolongs the dying process.

❑ I further direct that (check all boxes that apply):

❑ Treatment be given to maintain my dignity, keep me comfortable and relieve pain.

❑ If I **CANNOT** drink, I do not want to receive fluids through a needle or catheter placed in my body unless for comfort.

❑ If I **CANNOT** eat or refuse to eat, I do not want a tube inserted in my nose or mouth, or surgically placed in my stomach to give me food.

❑ If I have a serious infection, **I DO NOT** want antibiotics to prolong my life. Antibiotics may be used to treat a painful infection.

❑ Yes ❑ No I have attached additional directions regarding medical treatment to this form

***CONTINUED ON PAGE 2*** ⇨

# ADVANCE CARE PLAN (page 2 of 6)

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## CODE STATUS (CHOOSE ONE ONLY)

❑ **I want** CPR and intubation attempted if my heart stops and I stop breathing, unless my physician determines any one of the following:

- I have an incurable illness or injury and am dying; **OR**
- I have no reasonable chance of survival if my heart stops; **OR**
- I have little chance of long-term survival if my heart stops and the process of resuscitation would cause significant suffering.

❑ **I want** CPR and intubation attempted if my heart stops and I stop breathing.

❑ **I do not want** CPR and intubation attempted if my heart stops and I stop breathing, but want to permit a natural death.

### Chronic Illness or Serious Disability (Optional)

My chronic illness or disability can complicate an acute illness, but should not be misinterpreted as a terminal condition.

Diagnosis:_____

Physician Name:_____Phone:_____

Special directions (attach additional sheets as necessary):_____

_____

_____

Illnesses where I would only want comfort care:_____

_____

### Special Directions (Optional)

**A. Spiritual Preferences**

Religion/Faith:_____

Contact person:_____

I would like spiritual support: ❑ Yes ❑ No

**B. Where I Would Like to be When I Die if possible**

❑ My home ❑ Hospital ❑ Nursing home ❑ Other:_____

**C. If I reach a point where the doctors are reasonably certain that I will not regain my ability to interact meaningfully with family, friends, and the world around me and there is little chance for improvement, I would want:**

❑ Hospice (agency of choice :_____) ❑ Comfort Care without Hospice

❑ Full treatment until I pass ❑ Other:_____

***CONTINUED ON PAGE 3***

# ADVANCE CARE PLAN (page 3 of 6)

***Language interpretation and sign language services are available free of charge.***

**Special Directions (Optional) -** *continued from page 2*

**D. Donation of Organs/Tissue at My Death (check one of the following):**

❑ I do not wish to donate any of my body, organs, or tissue.

❑ I wish to donate only the following (check all that apply):

❑ Heart ❑ Kidneys ❑ Lungs ❑ Bone Marrow ❑ Eyes ❑ Skin ❑ Liver

❑ Other:_____

❑ I wish to donate **all** organs, tissues, or body parts

**E. After-Death Care:**

❑ Casket Burial (Funeral Home Preference :_____)

❑ Green Burial (Funeral Home Preference: _____)

❑ Cremation with burial

❑ Cremation with no burial (I have given specific instructions to family/friends)

❑ Donate Body to Science

**F. Additional Directions** (use additional pages if necessary): _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

***CONTINUED ON PAGE 4***

# ADVANCE CARE PLAN (page 4 of 6)

***Language interpretation and sign language services are available free of charge.***

## Health Care Representative (Power of Attorney for Health Care)

My Representative may make all health care decisions for me as authorized in this document and shall be given access to all my medical records. This appointment applies whether I am expected to recover or not.

**I wish to appoint a Representative** ☐ Yes ☐ No

### A. Primary Representative

I appoint as my Representative:_____

Print Representative's Full Name:_____

Representative's Address:_____

City:_____State:_____Zip: _____

Home Phone:_____Cell Phone:_____

My Representative's authority is effective when I cannot make health care decisions or communicate my wishes. I may revoke this authority at any time I regain these abilities (unless my attending physician and any necessary experts determine I am not capable of making decisions in my own best interest).

If, for any reason, I should need a guardian of my person designated by a court, I nominate my Representative, or Alternate Representative(s), named below.

### B. Alternate Representative(s)

If: 1. I revoke my Representative's authority; or 2. My Representative becomes unwilling or unable to act for me; or 3. My Representative is my spouse and I become legally separated or divorced, I name the following person(s) as alternates to my Representative in the order listed:

1. Alternative Representative's Full Name:_____
   Address:_____
   City:_____State:_____Zip:_____
   Phone: (Home)_____(Cell)_____(Work)_____

2. Alternative Representative's Full Name:_____
   Address:_____
   City:_____State:_____Zip:_____
   Phone: (Home)_____(Cell)_____(Work)_____

***CONTINUED ON PAGE 5***

# ADVANCE CARE PLAN (page 5 of 6)

***Language interpretation and sign language services are available free of charge.***

**Health Care Representative (Power of Attorney for Health Care)**

**BEFORE YOU SIGN, HAVE WITNESSES OR NOTARY PRESENT!** Witnesses cannot be designated POA, family member or care taker of the person who this document pertains to.

**Signing and Witnessing this Advance Directive (Witness)**

**Optional in the absence of Notary**

☐ I have reviewed or been instructed about the elements of advance care planning and have had my questions answered.

**A. Your Signature**

Ask two people to watch you sign and have them sign below. If you can, it's best to sign this document in front of a Notary Public.

1. I revoke any prior health care advance directive or directions.
2. This document is intended to be valid in any jurisdiction in which it is presented.
3. A copy of this document is intended to have the same effect as the original.
4. Those who act as I have directed in this document shall be free from legal liability for having followed my directions.
5. If my attending physician is unwilling or unable to comply with my wishes as stated in this document, I direct my care be transferred to a physician who will.

**I sign this document on the_____ day of_____, _____**

**Signature: _____**

**Print Full Name: _____**

**Address: _____**

**City:_____ State:_____ Zip:_____**

**Home/Cell Phone: _____ Work Phone: _____**

**B. Ask Your Witnesses to Read and Sign**

I declare that I am over the age of 18 and the person who signed this document has signed these health care advance directives in my presence, and appears to be of sound mind and under no duress, fraud or undue influence.

**Witness One:**

Date:_____

Signature:_____Printed Name: _____

Address:_____

City:_____State:_____Zip Code:_____

**Witness Two:**

Date:_____

Signature:_____Printed Name: _____

Address:_____

City:_____State:_____Zip Code:_____

***CONTINUED ON PAGE 6***

PATIENT IDENTIFICATION:

**St. Peter's Health**

**2475 Broadway • Helena, MT 59601 (406) 442-2480**

**ADVANCE CARE PLAN**

AD.DIR

**BEFORE YOU SIGN HAVE NOTARY PRESENT!**

***Language interpretation and sign language services are available free of charge.***

## Signing and Witnessing this Advance Directive (Notary)

**Optional in the absence of two witnesses**

☐ I have reviewed or been instructed about the elements of advance care planning and have had my questions answered.

**A. Your Signature**

Please sign in the presence of a Notary.

1. I revoke any prior health care advance directive or directions.
2. This document is intended to be valid in any jurisdiction in which it is presented.
3. A copy of this document is intended to have the same effect as the original.
4. Those who act as I have directed in this document shall be free from legal liability for having followed my directions.
5. If my attending physician is unwilling or unable to comply with my wishes as stated in this document, I direct my care be transferred to a physician who will.

**I sign this document on the_____ day of_____, _____**

**Signature: _____**

**Print Full Name: _____**

**Address: _____**

**City:_____ State:_____ Zip:_____**

**Home/Cell Phone: _____ Work Phone: _____**

**C. Notarizing This Document (required in the absence of two witnesses)**

STATE OF COUNTY OF_____

On this day_____ of _____, 20_____ , the said known to me (or satisfactorily proven) to be the person named in the foregoing instrument, personally appeared before me, a Notary Public within and for the State and County aforesaid, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.

Notary Public for the State of:_____

Residing at:_____

My commission expires:_____

Notary Signature:_____

***If sign language or limited English proficiency interpretive services were utilized:***

_____ _____

Interpreter Printed Name Interpreter Identification Number

☐ Patient has been given “My Choices” informational handout for Advance Directive, Living Will, POLST

**Montana Department of Justice**
**Office of Consumer Protection**

**MONTANA**
**END-OF-LIFE REGISTRY**
https://dojmt.gov/consumer/end-of-life-registry/

# Consumer Registration Agreement

For office use only

PO Box 201410, Helena, MT 59620-1410 • Phone (406) 444-0660 or (866) 675-3314 • E-mail: endofliferegistry@mt.gov

This form indicates your desire to store an advance directive in the Montana End-of-Life Registry, to replace or remove an Advance Directive already in the Registry, or to request a replacement wallet card.

- Read this Agreement carefully and fill in Sections A through C completely.
- Attach your witnessed Advance Directive.
- Return this Agreement with your Advance Directive to the Office of Consumer Protection at the address above.
- Your Consumer Registration Agreement will be processed within three weeks. You will receive further information in the mail.

## Section A

| Prefix | First Name | Middle Name or Initial | Last Name | Suffix |
|---|---|---|---|---|
| | | | | |

| Gender | Date of Birth (Month/Day/Year) | Mother's Maiden Name | Social Security Number | Phone Number |
|---|---|---|---|---|
| | | | | |

| Mailing Address | | | | |
|---|---|---|---|---|
| City | State | Zip | County | Country |
| | | | | |

## Section B

Pick a level of privacy:

- ☐ **Standard Privacy:** If the information on my wallet card is unavailable, in addition to health care providers, people who enter my Social Security Number, date of birth and mother's maiden name can view my advance directive.
- ☐ **Higher Privacy:** Only people who have the information from my wallet card and health care providers can view my advance directive.

I want to:

- ☐ **Store an advance directive in the Registry.**
- ☐ **Replace an advance directive in the Registry with a new one.**
- ☐ **Add an Addendum to my current directive**
- ☐ **Remove my advance directive from the Registry.**
- ☐ **Request a replacement wallet card.**

## Section C

I am providing this personal information along with my advance directive, with the understanding that my personal information will be stored in a secure Department of Justice database and will not be available to the public. I certify that the advance directive that accompanies this Agreement is my current effective advance directive and was duly executed, witnessed and acknowledged in accordance with Section 50-9-103 of the Montana Code Annotated.

I understand that:

- my advance directive will be entered in the Montana End-of-Life Registry free of charge;
- this authorization is voluntary;
- this authorization to store my advance directive in the Montana End-of-Life Registry will remain in force until I revoke it;
- I may revoke this authorization at any time by giving written notice of my revocation to the address listed above; and

no agency, provider or individual may be held liable for any action based on this authorization before a written notice of revocation has been entered into the Registry.

_____ _____

Signature of Person Signing This Agreement Date

If the person named in the advance directive is unable to sign this form, and you have legal authority to sign for that person, please check the source of your authority and provide proof thereof. □ Durable Power of Attorney □ Court Appointed Guardian

**For more information on Advance Care Planning contact:**

**St. Peter's Palliative Care**
**2475 Broadway**
**Helena, MT 59601**
**(406) 444-2137**

**Other contact numbers:**

**St. Peter's Health Regional Medical Center: (406) 442-2480**
**St. Peter's Health Medical Group - Broadway: (406) 459-6991**
**St. Peter's Health Medical Group - North: (406) 457-4180**
**St. Peter's Health Cancer Treatment Center: (406) 444-2381**

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