STATE OF NORTH CAROLINA

ADVANCE DIRECTIVE FOR A
NATURAL DEATH ("LIVING WILL')

COUNTY OF _____

NOTE: YOU SHOULD USE THIS DOCUMENT TO GIVE YOUR HEALTH CARE PROVIDERS INSTRUCTIONS TO WITHHOLD OR WITHDRAW LIFE-PROLONGING MEASURES IN CERTAIN SITUATIONS. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A LIVING WILL.

GENERAL INSTRUCTIONS: *You can use this Advance Directive ("Living Will") form to give instructions for the future if you want your health care providers to withhold or withdraw life-prolonging measures in certain situations. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctors, clergypersons, and lawyers before you complete and sign this Living Will.*

You do not have to use this form to give those instructions, but if you create your own Advance Directive you need to be very careful to ensure that it is consistent with North Carolina law.

This Living Will form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. Do not sign this form until two witnesses and a notary public are present to watch you sign it. You then should consider giving a copy to your primary physician and/or a trusted relative, and should consider filing it with the Advanced Health Care Directive Registry maintained by the North Carolina Secretary of State:
http://www.nclifelinks.org/ahcdr/

My Desire for a Natural Death

I, _____, being of sound mind, desire that, as specified below, my life not be prolonged by life-prolonging measures:

1. When My Directives Apply

My directions about prolonging my life shall apply *IF* my attending physician determines that I lack capacity to make or communicate health care decisions and:

NOTE: YOU MAY INITIAL ANY OR ALL OF THESE CHOICES.

_____ (Initial)	I have an incurable or irreversible condition that will result in my death within a relatively short period of time.
_____ (Initial)	I become unconscious and my health care providers determine that, to a high degree of medical certainty, I will never regain my consciousness.
_____ (Initial)	I suffer from advanced dementia or any other condition which results in the substantial loss of my cognitive ability and my health care providers determine that, to a high degree of medical certainty, this loss is not reversible.

2. These are My Directives about Prolonging My Life:

In those situations I have initialed in Section 1, I direct that my health care providers:

NOTE: INITIAL ONLY IN ONE PLACE.

_____ (Initial)	may withhold or withdraw life-prolonging measures.
_____ (Initial)	shall withhold or withdraw life-prolonging measures.

3. Exceptions – "Artificial Nutrition or Hydration"

NOTE: INITIAL ONLY IF YOU WANT TO MAKE EXCEPTIONS TO YOUR INSTRUCTIONS IN PARAGRAPH 2.

EVEN THOUGH I do not want my life prolonged in those situations I have initialed in Section 1:

_____ (Initial)	I *DO* want to receive BOTH artificial hydration AND artificial nutrition (for example, through tubes) in those situations. _____ **NOTE: DO NOT INITIAL THIS BLOCK IF ONE OF THE BLOCKS BELOW IS INITIALED.**
_____ (Initial)	I *DO* want to receive ONLY artificial hydration (for example, through tubes) in those situations. _____ **NOTE: DO NOT INITIAL THE BLOCK ABOVE OR BELOW IF THIS BLOCK IS INITIALED.**
_____ (Initial)	I *DO* want to receive ONLY artificial nutrition (for example, through tubes) in those situations. _____ **NOTE: DO NOT INITIAL EITHER OF THE TWO BLOCKS ABOVE IF THIS BLOCK IS INITIALED.**

4. I Wish to be Made as Comfortable as Possible

I direct that my health care providers take reasonable steps to keep me as clean, comfortable, and free of pain as possible so that my dignity is maintained, even though this care may hasten my death.

5. I Understand my Advance Directive

I am aware and understand that this document directs certain life-prolonging measures to be withheld or discontinued in accordance with my advance instructions.

6. If I have an Available Health Care Agent

If I have appointed a health care agent by executing a health care power of attorney or similar instrument, and that health care agent is acting and available and gives instructions that differ from this Advance Directive, then I direct that:

_____ (Initial)	Follow Advance Directive: This Advance Directive will override instructions my health care agent gives about prolonging my life.
_____ (Initial)	Follow Health Care Agent: My health care agent has authority to **override** this Advance Directive.

NOTE:* DO NOT INITIAL BOTH BLOCKS. *IF YOU DO NOT INITIAL EITHER BOX, THEN YOUR HEALTH CARE PROVIDERS WILL FOLLOW THIS ADVANCE DIRECTIVE AND IGNORE THE INSTRUCTIONS OF YOUR HEALTH CARE AGENT ABOUT PROLONGING YOUR LIFE.

7. My Health Care Providers May Rely on this Directive

My health care providers shall not be liable to me or to my family, my estate, my heirs, or my personal representative for following the instructions I give in this instrument. Following my directions shall not be considered suicide, or the cause of my death, or malpractice or unprofessional conduct. If I have revoked this instrument but my health care providers do not know that I have done so, and they follow the instructions in this instrument in good faith, they shall be entitled to the same protections to which they would have been entitled if the instrument had not been revoked.

8. I Want this Directive to be Effective Anywhere

I intend that this Advance Directive be followed by any health care provider in any place.

9. I have the Right to Revoke this Advance Directive

I understand that at any time I may revoke this Advance Directive in a writing I sign or by communicating in any clear and consistent manner my intent to revoke it to my attending physician. I understand that if I revoke this instrument I should try to destroy all copies of it.

This the _____ day of _____, _____.

_____
Signature of Declarant

_____
Type/Print Name

I hereby state that the declarant, _____, being of sound mind, signed (or directed another to sign on declarant's behalf) the foregoing Advance Directive for a Natural Death in my presence, and that I am not related to the declarant by blood or marriage, and I would not be entitled to any portion of the estate of the declarant under any existing will or codicil of the declarant or as an heir under the Intestate Succession Act, if the declarant died on this date without a will. I also state that I am not the declarant's attending physician, nor a licensed health

care provider who is (1) an employee of the declarant's attending physician, (2) nor an employee of the health facility in which the declarant is a patient, or (3) an employee of a nursing home or any adult care home where the declarant resides. I further state that I do not have any claim against the declarant or the estate of the declarant.

Date: _____ Witness: _____

Date: _____ Witness: _____

_____COUNTY, _____STATE

Sworn to (or affirmed) and subscribed before me this day by _____
(type/print name of declarant)

_____
(type/print name of witness)

_____
(type/print name of witness)

Date _____ _____
(Official Seal) *Signature of Notary Public*

_____, Notary Public
Printed or typed name

My commission expires: _____

I signed this notarial certificate on _____ according to the emergency video notarization
Date

requirements contained in G.S. 10B-25.

Notary Public location during video notarization: _____ County

Stated physical location of principal during video notarization: _____ County

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Medical Orders
for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the patient's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name:	Effective Date of Form:
Patient's First Name, Middle Initial:	Patient's Date of Birth:

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Attempt Resuscitation (CPR)** ☐ **Do Not Attempt Resuscitation (DNR/no CPR)**

When not in cardiopulmonary arrest, follow orders in **B, C**, and **D**.

Section B *Check One Box Only*

MEDICAL INTERVENTIONS: Patient has pulse and/or is breathing.

☐ **Full Scope of Treatment:** Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

☐ **Limited Additional Interventions:** Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation. May consider use of less invasive airway support such as BiPAP or CPAP. Also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

☐ **Comfort Measures:** Keep clean, warm and dry. Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions _____

Section C *Check One Box Only*

ANTIBIOTICS

☐ **Antibiotics if indicated**

☐ **Determine use or limitation of antibiotics when infection occurs**

☐ **No Antibiotics** (use other measures to relieve symptoms)

Other Instructions _____

Section D *Check One Box Only in Each Column*

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

☐ **IV fluids if indicated**

☐ **IV fluids for a defined trial period**

☐ **No IV fluids** (provide other measures to ensure comfort)

☐ **Feeding tube long-term if indicated**

☐ **Feeding tube for a defined trial period**

☐ **No feeding tube**

Other Instructions _____

Section E *Check The Appropriate Box*

DISCUSSED WITH AND AGREED TO BY:

☐ Patient

☐ Parent or guardian if patient is a minor

☐ Health care agent

☐ Legal guardian of the patient

☐ Attorney-in-fact with power to make health care decisions

☐ Spouse

☐ Majority of patient's reasonably available parents and adult children

☐ Majority of patient's reasonably available adult siblings

☐ An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

Basis for order must be documented in medical record.

MD/DO, PA, or NP Name (Print):	**MD/DO, PA, or NP Signature and Date** (Required):	**Phone #:**

Signature of Patient, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative
(Signature is required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.

You are not required to sign this form to receive treatment.

Patient or Representative Name (print)	Patient or Representative Signature	Relationship (write "self" if patient)

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY

Contact Information

Patient Representative:	Relationship:	Phone #: Cell Phone #:	
Health Care Professional Preparing Form:	Preparer Title:	Preferred Phone #:	Date Prepared:

Directions for Completing Form

Completing MOST

- MOST must be reviewed and prepared by a health care professional in consultation with the patient or patient representative.
- MOST is a medical order and must be signed and dated by a licensed physician (MD/DO), physician assistant, or nurse practitioner to be valid. **Be sure to document the basis for the order in the progress notes of the medical record.** Mode of communication (e.g., in person, by telephone, etc.) also should be documented.
- The signature of the patient or his/her representative is required; however, if the patient's representative is not reasonably available to sign the original form, a copy of the completed form with the signature of the patient's representative must be placed in the medical record and "on file" must be written in the appropriate signature field on the front of this form or in the review section below.
- Use of original form is required. **Be sure to send the original form with the patient.**
- MOST is part of advance care planning, which also may include a living will and health care power of attorney (HCPOA). If there is a HCPOA, living will, or other advance directive, a copy should be attached if available. **MOST may suspend any conflicting directions in a patient's previously executed HCPOA, living will, or other advance directive.**
- **There is no requirement that a patient have a MOST.**
- MOST is recognized under N. C. G en. Stat. 90-21.17.

Reviewing MOST

Review of the MOST form is recommended when:

- The patient is admitted to and/or discharged from a health care facility; or
- There is a substantial change in the patient's health status.

This MOST must be reviewed if:

- The patient's treatment preferences change.

If MOST is revised or becomes invalid, draw a line through Sections A – E and write "VOID" in large letters.

Revocation of MOST

A patient with capacity or the patient's representative (if the patient lacks capacity) can revoke the MOST at any time and request alternative treatment based on the known preferences of the patient or, if unknown, the patient's best interests.

Review of MOST

Review Date	Reviewer and location of review	MD/DO, PA, or NP Signature (required)	Signature of patient or representative (preferred)	Outcome of Review
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form
				☐No Change ☐FORM VOIDED, new form completed ☐FORM VOIDED, **no** new form

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

DO NOT ALTER THIS FORM!

NCDHHS/DHSR/OEMS
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North Carolina Department of Health and Human Services • Division of Health Service Regulation • Office of Emergency Medical Services
www.ncdhhs.gov • www.ncdhhs.gov/dhsr/EMS/ems.htm
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