STATE OF SOUTH CAROLINA)
)
COUNTY OF _____)

DECLARATION OF A DESIRE FOR A NATURAL DEATH

I, _____, Declarant, being at least eighteen years of age and a resident of and domiciled in the City of _____, County of _____, State of South Carolina, make this Declaration this _____ day of _____, 20_____.

I willfully and voluntarily make known my desire that no life-sustaining procedures be used to prolong my dying if my condition is terminal or if I am in a state of permanent unconsciousness, and I declare: If at any time I have a condition certified to be a terminal condition by two physicians who have personally examined me, one of whom is my attending physician, and the physicians have determined that my death could occur within a reasonably short period of time without the use of life-sustaining procedures or if the physicians certify that I am in a state of permanent unconsciousness and where the application of life-sustaining procedures would serve only to prolong the dying process, I direct that the procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure necessary to provide me with comfort care.

INSTRUCTIONS CONCERNING ARTIFICIAL NUTRITION AND HYDRATION

INITIAL ONE OF THE FOLLOWING STATEMENTS

1. If my condition is terminal and could result in death within a reasonably short time,

A._____I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

B._____I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

The following line is not part of the standard South Carolina form. It has been added at the request of many people as a point of clarification. If you do want it to apply, please initial the line below:

C._____Nevertheless, I do want treatment to ensure my comfort and to relieve pain and suffering and minimal intravenous fluids to avoid discomfort.

INITIAL ONE OF THE FOLLOWING STATEMENTS

2. If I am in a persistent vegetative state or other condition of permanent unconsciousness,

A._____I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

B._____I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

The following line is not part of the standard South Carolina form. It has been added at the request of many people as a point of clarification. If you do want it to apply, please initial the line below:

C._____ Nevertheless, I do want treatment to ensure my comfort and to relieve pain and suffering and minimal intravenous fluids to avoid discomfort.

3. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this Declaration be honored by my family and physicians and any health facility in which I may be a patient as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from the refusal.

4. I am aware that this Declaration authorizes a physician to withhold or withdraw life-sustaining procedures. I am emotionally and mentally competent to make this Declaration.

APPOINTMENT OF AN AGENT (OPTIONAL)

1. You may give another person authority to revoke this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.
Name of Agent with Power to Revoke: _____
Address:_____
Telephone Number:_____

2. You may give another person authority to enforce this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.
Name of Agent with Power to Enforce: _____
Address: _____
Telephone Number: _____

REVOCATION PROCEDURES

THIS DECLARATION MAY BE REVOKED BY ANY ONE OF THE FOLLOWING METHODS. HOWEVER, A REVOCATION IS NOT EFFECTIVE UNTIL IT IS COMMUNICATED TO THE ATTENDING PHYSICIAN.

(1) BY BEING DEFACED, TORN, OBLITERATED, OR OTHERWISE DESTROYED, IN EXPRESSION OF YOUR INTENT TO REVOKE, BY YOU OR BY SOME PERSON IN YOUR PRESENCE AND BY YOUR DIRECTION. REVOCATION BY DESTRUCTION OF ONE OR MORE OF MULTIPLE ORIGINAL DECLARATIONS REVOKES ALL OF THE ORIGINAL DECLARATIONS;

(2) BY A WRITTEN REVOCATION SIGNED AND DATED BY YOU EXPRESSING YOUR INTENT TO REVOKE;

(3) BY YOUR ORAL EXPRESSION OF YOUR INTENT TO REVOKE THE DECLARATION. AN ORAL REVOCATION COMMUNICATED TO THE ATTENDING PHYSICIAN BY A PERSON OTHER THAN YOU IS EFFECTIVE ONLY IF:

(A) THE PERSON WAS PRESENT WHEN THE ORAL REVOCATION WAS MADE;

(B) THE REVOCATION WAS COMMUNICATED TO THE PHYSICIAN WITHIN A REASONABLE TIME;

(C) YOUR PHYSICAL OR MENTAL CONDITION MAKES IT IMPOSSIBLE FOR THE PHYSICIAN TO CONFIRM THROUGH SUBSEQUENT CONVERSATION WITH YOU THAT THE REVOCATION HAS OCCURRED.

TO BE EFFECTIVE AS A REVOCATION, THE ORAL EXPRESSION CLEARLY MUST INDICATE YOUR DESIRE THAT THE DECLARATION NOT BE GIVEN EFFECT OR THAT LIFE-SUSTAINING PROCEDURES BE ADMINISTERED;

(4) IF YOU, IN THE SPACE ABOVE, HAVE AUTHORIZED AN AGENT TO REVOKE THE DECLARATION, THE AGENT MAY REVOKE ORALLY OR BY A WRITTEN, SIGNED, AND DATED INSTRUMENT. AN AGENT MAY REVOKE ONLY IF YOU ARE INCOMPETENT TO DO SO. AN AGENT MAY REVOKE THE DECLARATION PERMANENTLY OR TEMPORARILY.

(5) BY YOUR EXECUTING ANOTHER DECLARATION AT A LATER TIME.

_____

Declarant

STATE OF SOUTH CAROLINA)
)
COUNTY OF _____)

AFFIDAVIT

We, _____ and _____, the undersigned witnesses to the foregoing Declaration, dated this _____ day of _____, 20__, at least one of us being first duly sworn, declare to the undersigned authority, on the basis of our best information and belief, that the Declaration was on that date signed by the Declarant as and for his DECLARATION OF A DESIRE FOR A NATURAL DEATH in our presence and we, at her request and in her presence, and in the presence of each other, subscribe our names as witnesses on that date. The Declarant is personally known to us, and we believe her to be of sound mind. Each of us affirms that he/she is qualified as a witness to this Declaration under the provisions of the South Carolina Death With Dignity Act in that he/she is not related to the Declarant by blood, marriage, or adoption, either as a spouse, lineal ancestor, descendant of the parents of the Declarant, or spouse of any of them; nor directly financially responsible for the Declarant's medical care; nor entitled to any portion of the Declarant's estate upon his decease, whether under

any will or as an heir by intestate succession; nor the beneficiary of a life insurance policy of the Declarant; nor the Declarant's attending physician; nor an employee of the attending physician; nor a person who has a claim against the Declarant's decedent's estate as of this time. No more than one of us is an employee of a health facility in which the Declarant is a patient. If the Declarant is a resident in a hospital or nursing care facility at the date of execution of this Declaration, at least one of us is an ombudsman designated by the State Ombudsman, Office of the Governor.

_____ _____

Witness Witness

Subscribed, sworn to, and acknowledged before me by _____, the Declarant, and subscribed and sworn to before me by _____ and _____, the witnesses, this _____ day of _____, 20____.

_____ (SEAL)
Notary Public for South Carolina
My Commission Expires:_____

SOUTH CAROLINA HEALTH CARE POWER OF ATTORNEY

INFORMATION ABOUT THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU NAME AS YOUR AGENT THE POWER TO MAKE HEALTH CARE DECISIONS FOR YOU IF YOU CANNOT MAKE THE DECISION FOR YOURSELF. THIS POWER INCLUDES THE POWER TO MAKE DECISIONS ABOUT LIFE-SUSTAINING TREATMENT. UNLESS YOU STATE OTHERWISE, YOUR AGENT WILL HAVE THE SAME AUTHORITY TO MAKE DECISIONS ABOUT YOUR HEALTH CARE AS YOU WOULD HAVE.

2. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENTS OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. YOU MAY STATE IN THIS DOCUMENT ANY TREATMENT YOU DO NOT DESIRE OR TREATMENT YOU WANT TO BE SURE YOU RECEIVE. YOUR AGENT WILL BE OBLIGATED TO FOLLOW YOUR INSTRUCTIONS WHEN MAKING DECISIONS ON YOUR BEHALF. YOU MAY ATTACH ADDITIONAL PAGES IF YOU NEED MORE SPACE TO COMPLETE THE STATEMENT.

3. AFTER YOU HAVE SIGNED THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE HEALTH CARE DECISIONS FOR YOURSELF IF YOU ARE MENTALLY COMPETENT TO DO SO. AFTER YOU HAVE SIGNED THIS DOCUMENT, NO TREATMENT MAY BE GIVEN TO YOU OR STOPPED OVER YOUR OBJECTION IF YOU ARE MENTALLY COMPETENT TO MAKE THAT DECISION.

4. YOU HAVE THE RIGHT TO REVOKE THIS DOCUMENT, AND TERMINATE YOUR AGENT'S AUTHORITY, BY INFORMING EITHER YOUR AGENT OR YOUR HEALTH CARE PROVIDER ORALLY OR IN WRITING.

5. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A SOCIAL WORKER, LAWYER, OR OTHER PERSON TO EXPLAIN IT TO YOU.

6. THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS TWO PERSONS SIGN AS WITNESSES. EACH OF THESE PERSONS MUST EITHER WITNESS YOUR SIGNING OF THE POWER OF ATTORNEY OR WITNESS YOUR ACKNOWLEDGMENT THAT THE SIGNATURE ON THE POWER OF ATTORNEY IS YOURS.

THE FOLLOWING PERSONS MAY NOT ACT AS WITNESSES:

A. YOUR SPOUSE, YOUR CHILDREN, GRANDCHILDREN, AND OTHER LINEAL DESCENDANTS; YOUR PARENTS, GRANDPARENTS, AND OTHER LINEAL ANCESTORS; YOUR SIBLINGS AND THEIR LINEAL DESCENDANTS; OR A SPOUSE OF ANY OF THESE PERSONS.

B. A PERSON WHO IS DIRECTLY FINANCIALLY RESPONSIBLE FOR YOUR MEDICAL CARE.

C. A PERSON WHO IS NAMED IN YOUR WILL, OR, IF YOU HAVE NO WILL, WHO WOULD INHERIT YOUR PROPERTY BY INTESTATE SUCCESSION.

D. A BENEFICIARY OF A LIFE INSURANCE POLICY ON YOUR LIFE.

E. THE PERSONS NAMED IN THE HEALTH CARE POWER OF ATTORNEY AS YOUR AGENT OR SUCCESSOR AGENT.

F. YOUR PHYSICIAN OR AN EMPLOYEE OF YOUR PHYSICIAN.

G. ANY PERSON WHO WOULD HAVE A CLAIM AGAINST ANY PORTION OF YOUR ESTATE (PERSONS TO WHOM YOU OWE MONEY).

IF YOU ARE A PATIENT IN A HEALTH FACILITY, NO MORE THAN ONE WITNESS MAY BE AN EMPLOYEE OF THAT FACILITY.

7. YOUR AGENT MUST BE A PERSON WHO IS 18 YEARS OLD OR OLDER AND OF SOUND MIND. IT MAY NOT BE YOUR DOCTOR OR ANY OTHER HEALTH CARE PROVIDER THAT IS NOW PROVIDING YOU WITH TREATMENT; OR AN EMPLOYEE OF YOUR DOCTOR OR PROVIDER; OR A SPOUSE OF THE DOCTOR, PROVIDER, OR EMPLOYEE; UNLESS THE PERSON IS A RELATIVE OF YOURS.

8. YOU SHOULD INFORM THE PERSON THAT YOU WANT HIM OR HER TO BE YOUR HEALTH CARE AGENT. YOU SHOULD DISCUSS THIS DOCUMENT WITH YOUR AGENT AND YOUR PHYSICIAN AND GIVE EACH A SIGNED COPY. IF YOU ARE IN A HEALTH CARE FACILITY OR A NURSING CARE FACILITY, A COPY OF THIS DOCUMENT SHOULD BE INCLUDED IN YOUR MEDICAL RECORD.

SOUTH CAROLINA HEALTH CARE POWER OF ATTORNEY

1. DESIGNATION OF HEALTH CARE AGENT

I, _____, hereby appoint:
(Principal)

(Agent's Name) _____

(Agent's Address) _____

Telephone: home: _____ work: _____ mobile:_____

as my agent to make health care decisions for me as authorized in this document.

Successor Agent: If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following as successors to my agent, each to act alone and successively, in the order named:

a. First Alternate Agent:

Address: _____

Telephone: home:_____ work:_____ mobile:_____

b. Second Alternate Agent:

Address:_____

Telephone: home:_____ work:_____ mobile:_____

Unavailability of Agent(s): If at any relevant time the agent or successor agents named here are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document.

2. EFFECTIVE DATE AND DURABILITY

By this document I intend to create a durable power of attorney effective upon, and only during, any period of mental incompetence, except as provided in Paragraph 3 below.

3. HIPAA AUTHORIZATION

When considering or making health care decisions for me, all individually identifiable health information and medical records shall be released without restriction to my health care agent(s) and/or my alternate health care agent(s) named above including, but not limited to, (i) diagnostic, treatment, other health care, and related insurance and financial records and information associated with any past, present, or future physical or mental health condition including, but not limited to, diagnosis or treatment of HIV/AIDS, sexually transmitted disease(s), mental illness, and/or drug or alcohol abuse and (ii) any written opinion relating to my health that such health care agent(s) and/or alternate health care agent(s) may have requested. Without limiting the generality of the foregoing, this release authority applies to all health information and medical records governed by the Health Information Portability and

Accountability Act of 1996 (HIPAA), 42 USC 1320d and 45 CFR 160-164; is effective whether or not I am mentally competent; has no expiration date; and shall terminate only in the event that I revoke the authority in writing and deliver it to my health care provider.

4. AGENT'S POWERS

I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in this document or otherwise expressed by me or known to my agent. In making any decision, my agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my agent cannot determine the choice I would want made, then my agent shall make a choice for me based upon what my agent believes to be in my best interests. My agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below.

Accordingly, unless specifically limited by the provisions specified below, my agent is authorized as follows:

A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation;

B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death;

C. To authorize my admission to or discharge, even against medical advice, from any hospital, nursing care facility, or similar facility or service;

D. To take any other action necessary to making, documenting, and assuring implementation of decisions concerning my health care, including, but not limited to, granting any waiver or release from liability required by any hospital, physician, nursing care provider, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility against medical advice, and pursuing any legal action in my name, and at the expense of my estate to force compliance with my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply.

E. The powers granted above do not include the following powers or are subject to the following rules or limitations:

_____

_____

_____

5. ORGAN DONATION (INITIAL ONLY ONE)

My agent may ____; may not ____ consent to the donation of all or any of my tissue or organs for purposes of transplantation.

6. EFFECT ON DECLARATION OF A DESIRE FOR A NATURAL DEATH (LIVING WILL)

I understand that if I have a valid Declaration of a Desire for a Natural Death, the instructions contained in the Declaration will be given effect in any situation to which they are applicable. My agent will have authority to make decisions concerning my health care only in situations to which the Declaration does

not apply.

7. STATEMENT OF DESIRES CONCERNING LIFE-SUSTAINING TREATMENT

With respect to any Life-Sustaining Treatment, I direct the following:

(INITIAL ONLY ONE OF THE FOLLOWING 3 PARAGRAPHS)

(1) ____ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

OR

(2) ___ DIRECTIVE TO WITHHOLD OR WITHDRAW TREATMENT. I do not want my life to be prolonged and I do not want life-sustaining treatment:

a. if I have a condition that is incurable or irreversible and, without the administration of life-sustaining procedures, expected to result in death within a relatively short period of time; or

b. if I am in a state of permanent unconsciousness.

OR

(3) ____ DIRECTIVE FOR MAXIMUM TREATMENT. I want my life to be prolonged to the greatest extent possible, within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedures.

8. STATEMENT OF DESIRES REGARDING TUBE FEEDING

With respect to Nutrition and Hydration provided by means of a nasogastric tube or tube into the stomach, intestines, or veins, I wish to make clear that in situations where life-sustaining treatment is being withheld or withdrawn pursuant to Item 7, (INITIAL ONLY ONE OF THE FOLLOWING THREE PARAGRAPHS):

(a) _____ GRANT OF DISCRETION TO AGENT. I do not want my life to be prolonged by tube feeding if my agent believes the burdens of tube feeding outweigh the expected benefits. I want my agent to consider the relief of suffering, my personal beliefs, the expense involved, and the quality as well as the possible extension of my life in making this decision.

OR

(b) _____ DIRECTIVE TO WITHHOLD OR WITHDRAW TUBE FEEDING. I do not want my life prolonged by tube feeding.

OR

(c) ____DIRECTIVE FOR PROVISION OF TUBE FEEDING. I want tube feeding to be provided within the standards of accepted medical practice, without regard to my condition, the chances I have for recovery, or the cost of the procedure, and without regard to whether other forms of life-sustaining treatment are being withheld or withdrawn.

IF YOU DO NOT INITIAL ANY OF THE STATEMENTS IN ITEM 8, YOUR AGENT WILL NOT

HAVE AUTHORITY TO DIRECT THAT NUTRITION AND HYDRATION NECESSARY FOR COMFORT CARE OR ALLEVIATION OF PAIN BE WITHDRAWN.

9. ADMINISTRATIVE PROVISIONS

A. I revoke any prior Health Care Power of Attorney and any provisions relating to health care of any other prior power of attorney.

B. This power of attorney is intended to be valid in any jurisdiction in which it is presented.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT.

I sign my name to this Health Care Power of Attorney on

this _____ day of _____, 20 ____. My current home address is:

_____

Principal's Signature:_____

Print Name of Principal:_____

I declare, on the basis of information and belief, that the person who signed or acknowledged this document (the principal) is personally known to me, that he/she signed or acknowledged this Health Care Power of Attorney in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. I am not related to the principal by blood, marriage, or adoption, either as a spouse, a lineal ancestor, descendant of the parents of the principal, or spouse of any of them. I am not directly financially responsible for the principal's medical care. I am not entitled to any portion of the principal's estate upon his decease, whether under any will or as an heir by intestate succession, nor am I the beneficiary of an insurance policy on the principal's life, nor do I have a claim against the principal's estate as of this time. I am not the principal's attending physician, nor an employee of the attending physician. No more than one witness is an employee of a health facility in which the principal is a patient. I am not appointed as Health Care Agent or Successor Health Care Agent by this document.

Witness No. 1

Signature:_____

Date:_____

Print Name:_____

Telephone:_____

Address:_____

_____

Witness No. 2

Signature:_____

Date:_____

Print Name:_____

Telephone:_____

Address:_____

_____

(This portion of the document is optional and is not required to create a valid health care power of attorney.)

STATE OF SOUTH CAROLINA

COUNTY OF_____

The foregoing instrument was acknowledged before me by Principal on _____,

20 _____.

Notary Public for South Carolina_____

My Commission Expires:_____

South Carolina
Physician Orders for Scope of Treatment (POST)

Patient's Diagnosis:

Patient Last Name:	**Patient First Name/MI:**
Patient Date of Birth: (MM/DD/YYYY)	**Patient/Legal Representative Phone Number:**
Social Security Number last 4 digits: (*Optional)* XXX-XX-	**Gender:** ☐ **M** ☐ **F** ☐ **Other**
Patient Mailing Address: (street/city/state/zip)	

Section A
Check One Box Only

CARDIOPULMONARY RESUSCITATION (CPR): Unresponsive, pulseless, & not breathing.

☐ **Attempt Resuscitation/CPR** (Selecting CPR requires Full Treatment in Section **B**.)

☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death.)

If patient is not in cardiopulmonary arrest, follow orders in **B**, **C** and **D.**

Section B
Check One Box Only

MEDICAL INTERVENTIONS: If patient has pulse and/or is breathing.

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer to hospital and/or intensive care unit if indicated.***
Treatment Plan: All treatments including breathing machine.

☐ **Limited Treatment.** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airways interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer to hospital, if indicated. Avoid ICU if possible.***
Treatment Plan: Provide basic medical treatments.

☐ **Comfort Measures Only.** Keep clean, warm and dry. Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort**.** ***Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.***
Treatment Plan: Provide treatments for comfort through symptom management.

Additional Orders:

Section C
Check One Box Only

ANTIBIOTICS

☐ Use antibiotics if life can be prolonged.
☐ Determine use or limitation of antibiotics when infection occurs.
☐ No antibiotics except for relief of pain and discomfort.

Additional Orders:

Section D
Check One Box in Each Column

ARTIFICIALLY ADMINISTERED NUTRITION AND FLUIDS: Offer food and fluids by mouth if feasible.

☐ Long-term artificial nutrition by tube.	☐ Long-term IV fluids.
☐ Trial period of artificial nutrition by tube.	☐ Trial period of IV fluids.
☐ Do not insert feeding tube.	☐ No IV fluids.
☐ Decide when/if the situation arises.	☐ Decide when/if the situation arises.
Additional Orders:	**Additional Orders:**

Section E
Signature of Physician, APRN, or PA

Signature of Physician, Advanced Practice Registered Nurse, or Physician Assistant

My signature below indicates to the best of my knowledge that the patient has been diagnosed with a serious illness or, based upon a medical diagnosis, may be expected to lose capacity within 12 months, and that these orders are consistent with the patient's medical condition, diagnosis, and preferences.

Physician/APRN/PA Signature: *(required)*	Physician/APRN/PA Name: *(print)*	☐ Physician ☐ APRN ☐ PA (*Select one*)
Date: (MM/DD/YYYY) (*required)*	Physician/APRN/PA Phone Number:	Physician/APRN/PA License #:

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Legal Representative ☐ Other:

Section F
Signature of Patient or Legal Representative

Signature of Patient or Legal Representative

I am aware that this form is voluntary. 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, physician assistant, or advanced practice registered nurse and this document reflects those treatment preferences. *If signed by a legal representative, preferences expressed must reflect patient's wishes as best understood by the legal representative.*

Signature: *(required)*		Relationship: (*write "self" if patient)*
Print Name:	Date: (MM/DD/YYYY) (*required*)	Phone Number:

Section G
Facilitator (if applicable)

Facilitator Assisting with POST Form Completion (if applicable)

Print Name:	Date: (MM/DD/YYYY)	Phone Number:

FORM MUST ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

POST Form	****ATTACH to Page 1****
Patient Full Name:	

Form Completion Information (Optional but Helpful)	
Reviewed patient's advance directive to confirm no conflict with POST form: (A POST form does not replace an advance directive such as a Health Care Power of Attorney or living will.)	☐ Yes; date of the document reviewed: _____ ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart) ☐ Advance directive not available ☐ No advance directive exists

- A POST form is a designated document designed for use as part of advance care planning, the use of which must be limited to situations where the patient has been diagnosed with a serious illness or, based upon medical diagnosis, may be expected to lose capacity within 12 months and consists of a set of medical orders signed by a patient's physician, APRN, or PA addressing key medical decisions consistent with patient goals of care concerning treatment at the end of life that is portable and valid across health care settings.
- A POST form executed in South Carolina as provided in the POST Act, or a similar form executed in another jurisdiction in compliance with the laws of that jurisdiction, must be deemed a valid expression of a patient's wishes as to health care. A South Carolina health care provider or health care facility may accept a properly executed POST form as a valid expression of whether the patient consents to the provision of health care in accordance with Section 44-66-10, et seq. of the South Carolina Adult Health Care Consent Act.
- The effective date of the form is the date the POST form has been completed, executed, and signed by the Physician/APRN/PA and the patient or the patient's legal representative.
- A copy, facsimile, or electronic version of a completed POST form is considered to be legal.
- **The execution of a POST form is always voluntary and is for a person with an advanced illness.** The POST form records a patient's wishes for medical treatment in the patient's current state of health. Preferred medical treatment as stated by the patient on the POST form may be changed at any time by the patient or a designated health care representative or health care agent of the patient to reflect the patient's new wishes in accordance with the POST Act.
- Any physician who is responsible for the creation and execution of a POST form shall make reasonable efforts to periodically review and update the POST form with the patient as the patient's needs dictate but at least once per year.
- A patient's legal representative is defined under the POST Act to mean a person with priority to make health care decisions for patient pursuant to Section 44-66-10, et seq. of the South Carolina Adult Health Care Consent Act.
- An APRN may create, execute and sign a POST form if authorized to do so by his or her practice agreement. The POST form must be for a patient of the APRN, the physician with whom the APRN has entered into a practice agreement, or both.
- A PA may create, execute, and sign a POST form if authorized to do so by his or her scope of practice guidelines. The POST form must be for a patient of that PA, the PA's supervising physician, or both.

Revocation of POST Form

- A POST form may be revoked at any time by an oral or written statement by the patient or a patient's legal representative.
- A revocation is only effective upon communication to the health care provider or health care facility by the patient or the patient's legal representative.
- The execution of a POST form by a patient, or the patient's legal representative, pursuant to the POST Act, automatically revokes any previously executed POST form.
- A POST form executed pursuant to the POST Act remains effective until revoked or until a new POST form is executed pursuant to the POST Act.

Nothing herein shall be construed as legal advice.

FORM MUST ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED