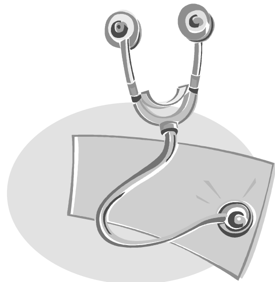
Pennsylvania Advance Health Care Directive

This form lets you have a say about how you want to be treated if you get very sick.

This form has 3 parts. It lets you:

Part 1: Choose a medical decision maker.

A medical decision maker is a person who can make health care decisions for you if you are too sick to make them yourself.



Part 2: Make your own health care choices.

This form lets you choose the kind of health care you want.

This way, those who care for you will not have to guess what you want if you are too sick to tell them yourself.

Part 3: Sign the form.

It must be signed before it can be used.

You can fill out Part 1, Part 2, or both.
Fill out only the parts you want. Always sign the form in Part 3.
2 witnesses need to sign on page 11.

YOUR NAME: ______________________________

If you only want to name a medical decision maker go to **Part 1** on page 3.

If you only want to make your own health care choices go to **Part 2** on page 6.

If you want both then fill out **Part 1 and Part 2.**

Always sign the form in Part 3 on page 9.

2 witnesses need to sign on page 11.

What if I change my mind?

- Fill out a new form.
- Tell those who care for you about your changes.
- Give the new form to your medical decision maker and doctor.

What if I have questions about the form?

Ask your doctors, nurses, social workers, friends or family to answer your questions. Lawyers can help too.

What if I want to make health care choices that are not on this form?

Write your choices on page 9.

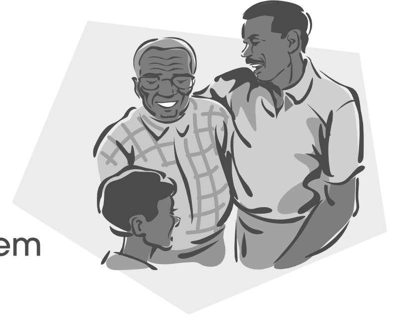
Share this form and your choices with your family, friends, and medical providers.

Part 1 Choose your medical decision maker

The person who can make health care decisions for you if you are too sick to make them yourself.

Whom should I choose to be my medical decision maker?

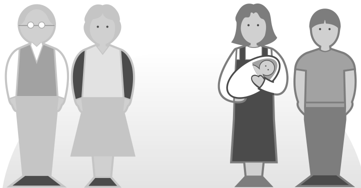
A family member or friend who:



- is at least 18 years old
- knows you well
- can be there for you when you need them
- you trust to do what is best for you
- can tell your doctors about the decisions you made on this form

Your decision maker cannot be your doctor or someone who works at your hospital or clinic, unless he/she is a family member.

What will happen if I do not choose a medical decision maker?



If you are too sick to make your own decisions, a person will be chosen for you according to Pennsylvania law. This person may not know what you want.

What kind of decisions can my medical decision maker make?

Agree to, say no to, change, stop or choose:

- doctors, nurses, social workers
- hospitals, clinics, or where you live
- medications, tests, or treatments
- what happens to your body and organs after you die

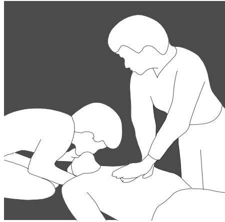
Your decision maker will need to follow the health care choices you make in Part 2.

Other decisions your medical decision maker can make:

Life support treatments – medical care to try to help you live longer

- **CPR or cardiopulmonary resuscitation**

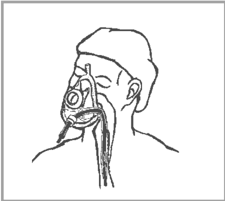
cardio = heart pulmonary = lungs resuscitation = to bring back



This may involve:

- pressing hard on your chest to keep your blood pumping
- electrical shocks to jump start your heart
- medicines in your veins

- **Breathing machine or ventilator**



The machine pumps air into your lungs and breathes for you.

You are not able to talk when you are on the machine.

- **Dialysis**
  A machine that cleans your blood if your kidneys stop working.

- **Feeding Tube**
  A tube used to feed you if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed by surgery.

- **Blood transfusions**
  To put blood in your veins.
- **Surgery**
- **Medicines**

End of life care – if you might die soon your medical decision maker can:

- call in a spiritual leader
- decide if you die at home or in the hospital
- decide where you should be buried

Show your medical decision maker this form.

Tell your decision maker what kind of medical care you want.

Your Medical Decision Maker

I want this person to make my medical decisions if I cannot make my own

first name last name

( ) – ( ) –

home number work number relationship

street address city state zip code

If the first person cannot do it, then I want this person to make my medical decisions.
Also, if the first person is a spouse and you divorce, the doctors will turn to this person.

first name last name

( ) – ( ) –

home number work number relationship

street address city state zip code

Put an X next to the sentence you agree with.

- ❑ My medical decision maker can make decisions for me right after I sign this form.
- ❑ My medical decision maker will make decisions for me **only** after I cannot make my own decisions.

How do you want your medical decision maker to follow your healthcare wishes?
Put an X next to the one sentence you most agree with.

- ❑ **Total Flexibility:** It is OK for my decision maker to change any of my medical decisions if my doctors think it is best for me at that time.
- ❑ **Some Flexibility:** It is OK for my decision maker to change some of my decisions if the doctors think it is best. But, these are some wishes I never want changed:

  ____

  ____

- ❑ **No flexibility:** I want my decision maker to follow my medical wishes exactly, no matter what. It is **not OK** to change my decisions, even if the doctors recommend it.

To make your own health care choices go to Part 2 on the next page.

If you are done, you must sign this form on page 9.

Part 2 Make your own health care choices

Write down your choices so those who care for you will not have to guess.

Think about what makes your life worth living.
Put an X next to all the sentences you most agree with.

My life is only worth living if I can:

- ❍ talk to family or friends
- ❍ wake up from a coma
- ❍ feed, bathe, or take care of myself
- ❍ be free from pain
- ❍ live without being hooked up to machines
- ❍ My life is always worth living no matter how sick I am
- ❍ I am not sure

If I am dying, it is important for me to be:

❑ at home ❑ in the hospital ❑ I am not sure

Is religion or spirituality important to you?

❑ no ❑ yes If you have one, what is your religion?

____

What should your doctors know about your religious or spiritual beliefs?

____

____

If you are sick, your doctors and nurses will always try to keep you comfortable and free from pain.

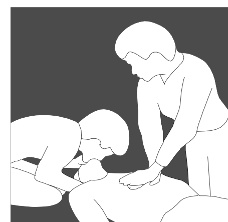
YOUR NAME: ______________________________

Life support treatments are used to try to keep you alive. These can be CPR, a breathing machine, feeding tubes, dialysis, blood transfusions, or medicine.

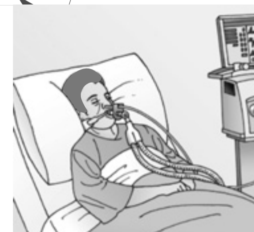
Please read this whole page before you make your choice.

Put an X next to the one choice you most agree with.

If I am so sick that I may die soon:



- ❑ Try all life support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, **I want to stay on life support machines** even if I am suffering.



- ❑ Try all life support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, **I do NOT want to stay on life support machines**. If I am suffering, I want to stop.

- ❑ **I do not want life support treatments**, and I want to focus on being comfortable. I prefer to have a natural death.

- ❑ I want my **medical decision maker** to decide for me.

- ❑ I am not sure.

*If you are pregnant and become unable to make decisions: Pennsylvania law may require your doctor to give you life support treatments even if you have an advance directive.

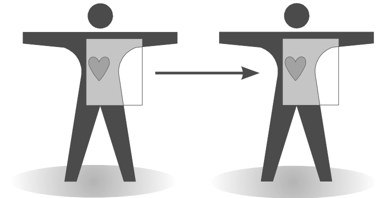
If you want to write down medical wishes that are not on this form, go to page 9.

YOUR NAME: ______________________________

Your doctors may ask about organ donation and autopsy after you die. Please tell us your wishes.

Put an X next to the one choice you most agree with.

Donating (giving) your organs can help save lives.



- ❑ I **want** to donate my organs.

  Which organs do you want to donate?

  - ❍ any organ
  - ❍ only_______________________

- ❑ I **do not** want to donate my organs.
- ❑ I want my **decision maker** to decide.
- ❑ I am not sure.

An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.

- ❑ I **want** an autopsy.
- ❑ I **do not** want an autopsy.
- ❑ I **only** want an autopsy if there are questions about my death.
- ❑ I want my **decision maker** to decide.
- ❑ I am not sure.

What should your doctors know about how you want your body to be treated after you die? Do you have funeral or burial wishes?

____

____

YOUR NAME: _______________________________

What other wishes are important to you?

____

____

____

____

____

____

____

____

____

____

Part 3 Sign the form

Before this form can be used, you must:

- sign this form if you are at least 18 years of age
- have two witnesses sign the form

Sign your name and write the date.

sign your name	date ___/___/___

print your first name	print your last name

address	city	state	zip code

Part 3 Witnesses

Before this form can be used you must have 2 witnesses sign the form

Your witnesses must:

- be over 18 years of age
- know you
- see you sign this form

Your witnesses cannot:

- be your medical decision maker
- be your health care provider
- work for your health care provider
- work at the place that you live

Also, one witness cannot:

- be related to you in any way
- benefit financially (get any money or property) after you die

Witnesses need to sign their names on the next page.

Have your witnesses sign their names and write the date

By signing, I promise that ______________________ (name) signed this form while I watched.

He/she was thinking clearly and was not forced to sign it.

I also promise that:

- I know this person and he/she could prove who he/she was.
- I am 18 years or older
- I am not his/her medical decision maker
- I am not his/her health care provider
- I do not work for his/her health care provider
- I do not work where he/she lives

One witness must also promise that:

- I am not related to him/her by blood, marriage, or adoption
- I will not benefit financially (get any money or property) after he/she dies

Witness #1

______________________________ / / ______

sign your name | date

print your first name | print your last name

address | city | state | zip code

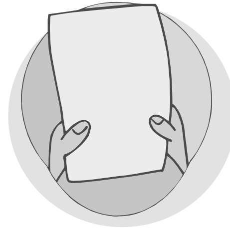
Witness #2

______________________________ / / ______

sign your name | date

print your first name | print your last name

address | city | state | zip code



You are now done with this form.

Share this form with your family, friends, and medical providers.
Talk with them about your medical wishes

This advance directive is in compliance with the Pennsylvania Probate Code 20 PA. C.S.A. §§ 5421-5431.
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Revised 3/10/2015
PATEX415377 SR/SK 03/15

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED
To follow these orders, an EMS provider must have an order from his/her medical command physician

Pennsylvania Orders for Life-Sustaining Treatment (POLST)

Last Name

First/Middle Initial

Date of Birth

FIRST follow these orders, **THEN** contact physician, certified registered nurse practitioner or physician assistant. This is an Order Sheet based on the person's medical condition and wishes at the time the orders were issued. Everyone shall be treated with dignity and respect.

A (Check One)

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

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

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

B (Check One)

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

☐ **COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for comfort. ***Do not transfer*** *to hospital for life-sustaining treatment.* ***Transfer*** *if comfort needs cannot be met in current location.*

☐ **LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, IV fluids and cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation.

Transfer *to hospital if indicated. Avoid intensive care if possible.*

☐ **FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.

Transfer *to hospital if indicated. Includes intensive care.*

Additional Orders ____

C (Check One)

ANTIBIOTICS:

☐ No antibiotics. Use other measures to relieve symptoms.

☐ Determine use or limitation of antibiotics when infection occurs, with comfort as goal

☐ Use antibiotics if life can be prolonged

Additional Orders

D (Check One)

ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION:

Always offer food and liquids by mouth if feasible

☐ No hydration and artificial nutrition by tube.

☐ Trial period of artificial hydration and nutrition by tube.

☐ Long-term artificial hydration and nutrition by tube.

Additional Orders

E (Check One)

SUMMARY OF GOALS, MEDICAL CONDITION AND SIGNATURES:

Discussed with
- ☐ Patient
- ☐ Parent of Minor
- ☐ Health Care Agent
- ☐ Health Care Representative
- ☐ Court-Appointed Guardian
- ☐ Other:

Patient Goals/Medical Condition:

By signing this form, I acknowledge that this request regarding resuscitative measures is consistent with the known desires of, and in the best interest of, the individual who is the subject of the form.

Physician /PA/CRNP Printed Name:	**Physician /PA/CRNP Phone Number**
Physician/PA/CRNP Signature (Required):	**DATE**

Signature of Patient or Surrogate

Signature (required)	**Name (print)**	**Relationship (write "self" if patient)**

PaDOH version 10-14-10

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

Other Contact Information

Surrogate	Relationship	Phone Number	
Health Care Professional Preparing Form	Preparer Title	Phone Number	Date Prepared

Directions for Healthcare Professionals

Any individual for whom a Pennsylvania Order for Life-Sustaining Treatment form is completed should ideally have an advance health care directive that provides instructions for the individual's health care and appoints an agent to make medical decisions whenever the patient is unable to make or communicate a healthcare decision. If the patient wants a DNR Order issued in section "A", the physician/PA/CRNP should discuss the issuance of an Out-of-Hospital DNR order, if the individual is eligible, to assure that an EMS provider can honor his/her wishes. Contact the Pennsylvania Department of Aging for information about sample forms for advance health care directives. Contact the Pennsylvania Department of Health, Bureau of EMS, for information about Out-of Hospital Do-Not-Resuscitate orders, bracelets and necklaces. POLST forms may be obtained online from the Pennsylvania Department of Health. www.health.state.pa.us

Completing POLST

Must be completed by a health care professional based on patient preferences and medical indications or decisions by the patient or a surrogate. This document refers to the person for whom the orders are issued as the "individual" or "patient" and refers to any other person authorized to make healthcare decisions for the patient covered by this document as the "surrogate."

At the time a POLST is completed, any current advance directive, if available, must be reviewed.

Must be signed by a physician/PA/CRNP and patient/surrogate to be valid. Verbal orders are acceptable with follow-up signature by physician/PA/CRNP in accordance with facility/community policy. A person designated by the patient or surrogate may document the patient's or surrogate's agreement. Use of original form is strongly encouraged. Photocopies and Faxes of signed POLST forms should be respected where necessary

Using POLST

If a person's condition changes and time permits, the patient or surrogate must be contacted to assure that the POLST is updated as appropriate.

If any section is not completed, then the healthcare provider should follow other appropriate methods to determine treatment.

An automated external defibrillator (AED) should not be used on a person who has chosen "Do Not Attempt Resuscitation"

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "comfort measures only," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

A person who chooses either "comfort measures only" or "limited additional interventions" may not require transfer or referral to a facility with a higher level of care.

An IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only."

Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate "Limited Additional Interventions" or "Full Treatment.

A patient with or without capacity or the surrogate who gave consent to this order or who is otherwise specifically authorized to do so, can revoke consent to any part of this order providing for the withholding or withdrawal of life-sustaining treatment, at any time, and request alternative treatment.

Review

This form should be reviewed periodically (consider at least annually) and a new form completed if necessary when:

(1) The person is transferred from one care setting or care level to another, or
(2) There is a substantial change in the person's health status, or
(3) The person's treatment preferences change.

Revoking POLST

If the POLST becomes invalid or is replaced by an updated version, draw a line through sections A through E of the invalid POLST, write "VOID" in large letters across the form, and sign and date the form.

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