ARKANSAS ADVANCE DIRECTIVE

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Agent: I want the following person to make health care decisions for me:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions **(you can check as many of these items as you want)**:

- ☐ **Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- ☐ **Permanent Confusion:** I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- ☐ **Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- ☐ **End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. **Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.**

☐ ☐ Yes No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ ☐ Yes No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
☐ ☐ Yes No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ ☐ Yes No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

PLEASE SIGN ON PAGE 2

DURABLE POWER OF ATTORNEY FOR HEALTH CARE OF

_____

Pursuant to the Arkansas Healthcare Decisions Act (Ark. Code Ann. § 20-6-101 et seq.) (the "Act"), I hereby designate and appoint _____ as my agent, or attorney-in-fact, whose phone number is _____, to make decisions regarding my health care during periods when my health care provider has determined that I lack capacity to decide for myself. Specifically, and not to limit any other rights prescribed under the Act, my attorney-in-fact shall have the following powers:

(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 have access to medical records and information to the same extent that I am entitled to, including the right to disclose the contents to others;

(c) To authorize my admission to or discharge, even against medical advice, from any hospital, nursing home, residential care, assisted living or similar facility or other healthcare facility;

(d) To contract on my behalf for any health care related service or facility on my behalf, without my agent incurring personal financial liability for such contracts;

(e) To select and discharge medical, social service, and other support personnel responsible for my care;

(f) 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;

(g) To take any other action necessary to do what I authorize here, including but not limited to granting any waiver or release from liability required by any hospital, physician, 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.

This Power of Attorney for Health Care shall give my agent the authority to make decisions about withholding or withdrawal of life-sustaining treatment, and nutrition and hydration, according to my wishes expressed in my Living Will, Health Care Directive, and/or Advance Care Plan, or if my wishes are unclear under the then existing circumstances of my medical condition, then upon consideration of my best interest as determined by my

physician in consultation with my attorney-in-fact.

If _____ resigns or is not able, available, or willing to make health care decisions for me, or if an agent named by me is divorced from me or is my spouse and legally separated from me, I appoint _____ as successor, with all of the rights and powers and authority herein stated. The term "health care" shall have the meaning set forth in Ark. Code Ann. § 20-6-102. This Durable Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity.

[If it becomes necessary for a court to appoint a guardian of my estate or guardian of my person, I nominate the following person for appointment [FULL NAME], who resides at [FULL ADDRESS], and whose phone number is [PHONE NUMBER].

SIGNED this ____ day of _____, 20____.

_____
Signature

We the undersigned, do hereby certify that the Declarant, _____, subscribed this Durable Power of Attorney for Health Care in our presence, and we, at his/her request, in his/her presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that the Declarant appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud, or restraint and that his or her signature was voluntary.

1. I am a competent adult who is not named as the agent. I witnessed the declarant's signature on this form.

_____
Print Witness Name

_____
Signature of Witness

2. I am a competent adult who is not named as the agent. I am not related to the declarant by blood, marriage, or adoption and I would not be entitled to any portion of the declarant's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the declarant's signature on this form.

_____
Print Witness Name

_____
Signature of Witness

ACKNOWLEDGMENT

STATE OF ARKANSAS)
COUNTY OF _____)

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the individual, _____. The individual personally appeared before me and signed above or acknowledged the signature above as his or her own on the ____ day of _____, 20____. I declare under penalty of perjury that the individual appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____

Signature of Notary Public

STATE OF ARKANSAS
EMERGENCY MEDICAL SERVICES
DO NOT RESUSCITATE ORDER

Patient's Full Name: _____

_____ _____

Signature of Patient or Health Care Proxy or Legal Guardian Date

ATTENDING PHYSICIAN'S ORDER

I, the undersigned, state that I am the physician for the patient named above.

I hereby direct any and all qualified Emergency Medical Services personnel, commencing on the effective date noted below, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide to the patient other medical interventions such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

_____ _____

Signature of Attending Physician Physician’s Telephone number (emergency #)

_____ _____

Physician's Printed/Typed Name Date Order Written

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Full Name	Date of Birth	Gender

Physician

Printed Name	Phone Number

Patient's Additional Contact

Printed Name	Phone Number

Directions for Physician Completing POLST Form

Completing the POLST Form

- **No patient is required to complete a POLST form.** The patient (or legal representative) signs the form to indicate the voluntary nature of the form and that the contents of the form are consistent with the patient's desires and values.
- **Upon arrival at or admission to a hospital or other facility, the POLST establishes initial treatment of the patient.** After evaluation of the patient in the hospital or other facility, additional appropriate orders may be issued consistent with the patient's preferences.
- **POLST does not replace a living will or other advance directive.** When available, review the advance directive and POLST form to ensure consistency and update forms appropriately to resolve any conflicts.
- **POLST must be completed by a physician based on patient preferences and values and medical indications.**
- **The legal representative of a patient may sign the POLST form if the patient lacks capacity.** A legal representative may include a court-appointed guardian, an agent designated in an advance directive, a spouse, an adult child, an adult sibling, an adult relative, or another surrogate whom the physician believes has exhibited special care and concern for the patient, is familiar with the patient's values, and will make decisions according to the patient's wishes and values.
- **To be valid, a POLST form must be signed by a physician and the patient or legal representative.** Both signatures are required.
- **If a translated POLST form is used with the patient or legal representative, attach the translation to the signed English POLST form.**
- **It is recommended that the POLST form be printed on bright pink paper, so it can be easily recognized among the patient's paperwork.** Use of the original POLST form is encouraged, but photocopies and faxes are legal and valid under Arkansas law.
- **To avoid any potential misunderstanding about nutrition and hydration, it is strongly recommended that physicians include the following statement in Section C , Additional Orders: "Offer food and drink by mouth, if feasible and desired."**

Using POLST

- An incomplete section of the POLST form implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment." If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."

Section C:

- **To avoid any potential misunderstanding about nutrition and hydration, it is strongly recommended that physicians include the following statement in Section C , Additional Orders: "Offer food and drink by mouth, if feasible and desired."**
- Depending on local EMS protocol, "Additional Orders" written in Section C may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. In addition, review is recommended when:

- The patient is transferred from one care setting or care level to another; or
- There is a substantial change in the patient's health status; or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means indicating intent to revoke.
- It is recommended that revocation be documented by drawing a line through Sections A through C, writing "VOID" in large letters, and signing and dating this line. A legal representative of a patient who lacks capacity may request to modify the orders after consulting with the physician, based on the known desires of the patient or, if unknown, the patient's best interests.

For more information or a copy of the POLST form, visit www. healthy.arkansas.gov.

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Arkansas Department of Health

5800 West Tenth Street Suite 400 ● Little Rock, Arkansas 72205-3867 ● Telephone (501) 661-2201
Governor Asa Hutchinson
Nathaniel Smith, MD, MPH, Director and State Health Officer
http://www.healthy.arkansas.gov

HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

First follow these orders, then contact **Physician**. A copy of the executed POLST form is a legally binding, valid physician order. Any section not completed implies full treatment for that section. **POLST complements an Advance Directive and is not intended to replace that document.**	Patient Last Name:	Date form Prepared:
	Patient First Name:	Patient Date of Birth:
	Patient Middle Name:	

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): ***If patient has no pulse and is not breathing.***
NOTE … If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.

☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)
☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B *Check One*

MEDICAL INTERVENTIONS: ***If patient is found with a pulse and/or is breathing.***

☐ **Full Treatment – primary goal of prolonging life by all medically effective means.**
In addition to treatment described in Selective Treatment and Comfort Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
☐ ***Trial Period of Full Treatment.***

☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.**
In addition to treatment described in Comfort Treatment, use medical treatment and IVs as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
☐ ***Request transfer to hospital only if comfort needs cannot be met in current location.***

☐ **Comfort Treatment – primary goal of maximizing comfort.**
Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

C

ADDITIONAL ORDERS:

D

INFORMATION AND SIGNATURES:

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legal Representative

☐ Advance Directive dated _____, available and reviewed
☐ Advance Directive not available.
☐ No Advance Directive.

Signature of Physician My signature below indicates to the best of my knowledge these orders are consistent with the patient's intentions and medical condition.

Print Physician Name:	Physician Phone Number:	Physician License #:
Physician Signature: *(required)*		Date:

Signature of Patient or Legal Representative I am aware my consent to this form is voluntary. By signing this form, a legal representative acknowledges this request regarding resuscitative measures is consistent with the known wishes of, and with the best interest of, the individual who is the subject of the form.

Print Name:	Relationship: *(write self if patient)*
Signature: *(required)*	Date:
Mailing Address:	Phone:

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Other instructions, such as burial arrangements, hospice care, etc.: _____

_____

_____

_____

_____

(Attach additional pages if necessary)

Organ donation (optional): Upon my death, I wish to make the following anatomical gift (please mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

_____

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

Signature: _____ DATE: _____
(Patient)

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

This document may be notarized instead of witnessed:

STATE OF ARKANSAS
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE

- Provide a copy to your physician(s)
- Keep a copy in your personal files where it is accessible to others
- Tell your closest relatives and friends what is in the document
- Provide a copy to the person(s) you named as your health care agent