Reset Form

STATE OF INDIANA
OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

State Form 49559 (R / 9-11)

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION

Declaration made this _____ day of _____, _____, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below.

I declare:
My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this Out of Hospital Do Not Resuscitate Declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

I understand the full import of this declaration

Signature of declarant
Printed name of declarant
City and state of residence

The declarant is personally known to me, and I believe the declarant to be of sound mind. I did not sign the declarant's signature above, for, or at the direction of, the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Signature of witness	Printed name	Date *(month, day, year)*
Signature of witness	Printed name	Date *(month, day, year)*

OUT OF HOSPITAL DO NOT RESUSCITATE ORDER

I, _____, the attending physician of _____, have certified the declarant as a qualified person to make an Out Of Hospital Do Not Resuscitate Declaration, and I order health care providers having actual notice of this Out Of Hospital Do Not Resuscitate Declaration and Order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the Out Of Hospital Do Not Resuscitate Declaration is revoked.

Signature of attending physician		
Printed name of attending physician	Medical license number	Date *(month, day, year)*

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INDIANA LIFE PROLONGING PROCEDURES DECLARATION

State Form 55315 (6-13)
Indiana State Department of Health – IC 16-36-4

This declaration is effective on the date of execution and remains in effect until revocation or the death of the declarant. This declaration should be provided to your physician.

LIFE PROLONGING PROCEDURES DECLARATION

Declaration made this _____ day of _____ *(month, year)*. I, _____ , being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition I request the use of life prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.

I understand the full import of this declaration.

Signed _____

_____
City, County, and State of Residence

WITNESSES

The declarant has been personally known to me and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years of age.

Witness _____ Date *(month, day, year)* _____

Witness _____ Date *(month, day, year)* _____

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INDIANA LIVING WILL DECLARATION

State Form 55316 (6-13)
Indiana State Department of Health – IC 16-36-4

This declaration is effective on the date of execution and remains in effect until revocation or the death of the declarant. This declaration should be provided to your physician.

LIVING WILL DECLARATION

Declaration made this _____ day of _____ *(month, year)*. I, _____ , being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that:
(1) I have an incurable injury, disease, or illness;
(2) my death will occur within a short time; and
(3) the use of life prolonging procedures would serve only to artificially prolong the dying process,

I direct that such procedures be withheld or withdrawn and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. *(Indicate your choice by initialing or making your mark before signing this declaration.)*:

_____ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

_____ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

_____ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full import of this declaration.

Signed _____

_____
City, County, and State of Residence

WITNESSES

The declarant has been personally known to me and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness _____ Date *(month, day, year)* _____

Witness _____ Date *(month, day, year)* _____

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INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

State Form 55317 (R3 / 5-18)
Indiana State Department of Health – IC 16-36-6

INSTRUCTIONS: This form is a physician's order for scope of treatment based on the patient's current medical condition and preferences. The POST should be reviewed whenever the patient's condition changes. A POST form is voluntary. A patient is not required to complete a POST form. A patient with capacity or their legal representative may void a POST form at any time by communicating that intent to the health care provider. Any section not completed does not invalidate the form and implies full treatment for that section. HIPAA permits disclosure to health care professionals as necessary for treatment. The original form is personal property of the patient. A facsimile, paper, or electronic copy of this form is a valid form.

Patient Last Name	Patient First Name	Middle Initial
Birth Date *(mm/dd/yyyy)*	Medical Record Number	Date Prepared *(mm/dd/yyyy)*

DESIGNATION OF PATIENT'S PREFERENCES: The following sections (A through D) are the patient's current preferences for scope of treatment.

A *Check One*

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

☐ Attempt Resuscitation / CPR ☐ Do Not Attempt Resuscitation / DNR

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

B *Check One*

MEDICAL INTERVENTIONS: If patient has pulse AND is breathing OR has pulse and is NOT breathing.

☐ Comfort Measures (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. 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 to hospital only if comfort needs cannot be met in current location.

☐ Limited Additional Interventions: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

☐ Full Intervention: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

C *Check One*

ANTIBIOTICS:

☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means.

☐ Use antibiotics consistent with treatment goals.

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluid by mouth if feasible.

☐ No artificial nutrition.

☐ Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____)

☐ Long-term artificial nutrition.

OPTIONAL ADDITIONAL ORDERS:

SIGNATURE PAGE: This form consists of two (2) pages. Both pages must be present. The following page includes signatures required for the POST form to be effective.

Patient Name:_____ Date of Birth *(mm/dd/yyyy)*:_____

	SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE: In order for the POST form to be effective, the patient or legally appointed representative must sign and date the form below.
E	**SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE** My signature below indicates that my physician or physician's designee discussed with me the above orders and the selected orders correctly represent my wishes.

Signature ***(required by statute)***	Print Name ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*

F	**CONTACT INFORMATION FOR LEGALLY APPOINTED REPRESENTATIVE IN SECTION E *(IF APPLICABLE)*:** If the signature above is other than patient's, add contact information for the representative.

Relationship of representative identified in Section E if patient does not have capacity ***(required by statute)***	Address *(number and street, city, state, and ZIP code)*	Telephone Number

PHYSICIAN ORDER:

A POST form may be executed only by an individual's treating physician, advanced practice registered nurse, or physician assistant, and only if:

(1) the treating physician, advanced practice registered nurse, or physician assistant has determined that:
- (A) the individual is a qualified person; and
- (B) the medical orders contained in the individual's POST form are reasonable and medically appropriate for the individual; and

(2) the qualified person or representative has signed and dated the POST form

A qualified person is an individual who has at least one (1) of the following:

(1) An advanced chronic progressive illness.
(2) An advanced chronic progressive frailty.
(3) A condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty:
- (A) there can be no recovery; and
- (B) death will occur from the condition within a short period without the provision of life prolonging procures.

(4) A medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

G **DOCUMENTATION OF DISCUSSION: Orders discussed with *(check one)*:**

☐ Patient (patient has capacity) ☐ Health Care Representative ☐ Legal Guardian
☐ Parent of Minor ☐ Health Care Power of Attorney

H **SIGNATURE OF TREATING PHYSICIAN / ADVANCED PRACTICE REGISTERED NURSE / PHYSICIAN ASSISTANT**

My signature below indicates that I or my designee have discussed with the patient or patient's representative the patient's goals and treatment options available to the patient based on the patient's health. My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

Signature of Treating Physician / APRN / PA ***(required by statute)***	Print Treating Physician / APRN / PA Name ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*

Physician / APRN / PA office telephone number ***(required by statute)***	Physician / APRN / PA License Number ***(required by statute)***	Health Care Professional preparing form if other than the physician / APRN / PA

I **APPOINTMENT OF HEALTH CARE REPRESENTATIVE:** As patient you have the option to appoint an individual to serve as your health care representative pursuant to IC 16-36-1-7. You are not required to designate a health care representative for this POST form to be effective. You are encouraged to consult with your attorney or other qualified individual about advance directives that are available to you. Forms and additional information about advance directives may be found on the ISDH web site at http://www.in.gov/isdh/25880.htm.

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INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

State Form 56184 (11-16)
Indiana State Department of Health – IC 16-36-1; IC 16-36-6

INSTRUCTIONS: See instructions on back.

Patient / Appointor Information		
Patient Last Name	Patient First Name	Patient Middle Initial
Patient Birthday *(mm/dd/yyyy)*	Medical Record Number of Healthcare Facility or Provider *(optional)*	Healthcare Facility or Provider *(optional)*

Appointment of Health Care Representative

I, being at least eighteen (18) years of age, of sound mind, and capable of consenting to my health care, hereby appoint the person(s) named below as my lawful health care representative in all matters affecting my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities, unless otherwise provided in this appointment. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care. I understand that if I have previously named a health care representative the designation below supersedes (replaces) any prior named Health Care Representative(s).

I authorize my health care representative to make decisions in my best interest concerning withdrawal or withholding of health care. If at any time based on my previously expressed preferences and the diagnosis and prognosis my health care representative is satisfied that certain health care is not or would not be beneficial or that such health care is or would be excessively burdensome, then my health care representative may express my will that such health care be withheld or withdrawn and may consent on my behalf that any or all health care be discontinued or not instituted, even if death may result. My health care representative must try to discuss this decision with me. However, if I am unable to communicate, my health care representative may make such a decision for me, after consultation with my physician or physicians and other relevant health care givers. To the extent appropriate, my health care representative may also discuss this decision with my family and others to the extent they are available.

I specify the following terms and conditions *(if any)*:

Name of Representative Appointed	Address of Representative *(number and street, city, state, and ZIP code)*	Telephone Number of Representative
Signature of Patient / Appointor or Designee *(must be signed in the appointor's presence)*	Printed Name of Patient / Appointor or Designee	Date of Appointment *(mm/dd/yyyy)*
Signature of Witness	Printed Name of Witness	Date *(mm/dd/yyyy)*

INSTRUCTIONS FOR STATE FORM 56184, INDIANA HEALTH CARE REPRESENTATIVE APPOINTMENT

1. There are numerous types of advance directives. The Indiana State Department of Health encourages individuals to consult with their attorney, health planner, and health care providers in completing any advance directive.

2. This state form is not required for an appointment of a health care representative. An individual may use a form designed by their attorney or other entity to specifically meet the individual's needs. To be valid, any form must comply with statutory requirements.

3. An individual is not required to complete a health care representative appointment form. An individual may always chose to not appoint a health care representative. If there is no appointed representative, state medical consent laws would determine who may consent to your healthcare.

4. The medical record number and health care facility or provider is not required for the appointment to be effective. It may be included as a means of assisting the health care provider in identifying the correct patient and locating the appointment in the correct medical record.

5. The patient / appointor may specify in the appointment appropriate terms and conditions, including an authorization to the representative to delegate the authority to consent to another.

6. The authority granted becomes effective according to the terms of the appointment.

7. The appointment does not commence until the appointor becomes incapable of consenting. The authority granted in the appointment is not effective if the patient / appointor regains the capacity to consent.

8. Unless the appointment provides otherwise, a representative appointed under this section who is reasonably available and willing to act has priority to act in all matters of health care for the patient / appointor, except when the patient / appointor is capable of consenting.

9. The appointment of a health care representative must be witnessed by an adult other than the health care representative.

10. In making all decisions regarding the patient's / appointor's health care, the health care representative shall act:
    a. In the best interest of the patient / appointor consistent with the purpose expressed in the appointment.
    b. In good faith.

11. A health care representative who resigns or is unwilling to comply with the written appointment may not exercise further power under the appointment and shall so inform the following:
    a. The patient / appointor.
    b. The patient's / appointor's legal representative if one is known.
    c. The health care provider if the representative knows there is one.

12. An individual who is capable of consenting to health care may revoke:
    a. The appointment at any time by notifying the representative orally or in writing; or
    b. The authority granted to the representative by notifying the health care provider orally or in writing.

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