ADVANCE HEALTHCARE DIRECTIVE FORM

This Advance Healthcare Directive form, created as a courtesy by Lancaster General Health, consists of both a Healthcare Power of Attorney and a Living Will. This document expresses my wishes and instructions for medical care when I am unable to make medical decisions for myself.

My Personal Information

Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: (_____) _____

Date of Birth: _____

PART I: HEALTHCARE POWER OF ATTORNEY

Part I allows you to appoint a person to make healthcare decisions for you when you are unable to make healthcare decisions for yourself. If you do not appoint a person in this Part I, the person(s) identified in 20 Pa.C.S.A. §5461(d) are authorized to make healthcare decisions for you.

A. No Healthcare Agent

Initial the box below if you choose not to appoint a person to make healthcare decisions for you when you are unable to make healthcare decisions for yourself. You are not required to appoint a person. If you initial the box below, DO NOT complete Sections B, C, D, and E, below.

_____ I choose not to appoint a healthcare agent.

B. My Healthcare Agent

I designate the person below to be my healthcare agent:

Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: (_____) _____ Cell Phone: (_____) _____

C. My First Alternate Healthcare Agent

If the person in Section B is unable or unwilling to serve as my healthcare agent, I appoint the following individual as my alternate healthcare agent:

Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: (_____)_____ Cell Phone: (_____)_____

My Second Alternate Healthcare Agent

If my first alternate healthcare agent is unable or unwilling to serve as my healthcare agent, I appoint the following individual as my second alternate healthcare agent:

Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: (_____)_____ Cell Phone: (_____)_____

D. Authority of My Healthcare Agent

My healthcare agent has the authority to make the following healthcare decisions for me in the event I am unable to make these healthcare decisions for myself. (*You may cross out any healthcare decisions below that you do not want your healthcare agent to make.*)

1. To authorize, withhold, or withdraw medical care and surgical procedures.
2. To authorize, withhold, or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries, or veins.
3. To authorize my admission to, or discharge from, a medical, nursing, residential, or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.
4. To hire and fire medical, social service, and other support personnel responsible for my care.
5. To take any legal action necessary to do what I have directed.
6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.

E. Additional Authority of My Healthcare Agent

1. If I suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such condition intolerable and the application of aggressive medical care to be burdensome. I therefore request that my healthcare agent respond to any intervening life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated in Part II. (*Initial your choice below*)

_____ I Agree _____ I Disagree

2. Below, I list some things which are important to me and provide additional instructions or directions to my healthcare agent:

_____

_____

_____

_____

PART II: LIVING WILL

The following healthcare treatment instructions exercise my right to make my own healthcare decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make, or communicate my treatment instructions and I am permanently unconscious or in an end-stage medical condition.

A. If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious such as in an irreversible coma or an irreversible vegetative state, and there is no realistic hope of significant recovery, then I choose the following (*initial your choice below*):

_____ **I DO NOT** want aggressive medical care and give the following instructions:

1. I direct that I be given healthcare treatment to relieve pain or provide comfort even if such treatment may shorten my life, suppress my appetite or breathing, or be habit forming.

2. I direct that all life prolonging procedures be withheld or withdrawn.

3. I do not want any of the following life prolonging procedures: CPR; mechanical ventilation; dialysis; surgery; chemotherapy; radiation treatment; or antibiotics.

_____ **I DO** want aggressive medical treatment and want my healthcare team to attempt to prolong my life as long as possible within the limits of generally accepted medical standards.

B. Additional Information

1. I indicate below whether I want nutrition (food) or hydration (water) medically supplied by a tube through my nose, stomach, intestine, arteries, or veins if I have an end-stage medical condition or I am permanently unconscious and there is no realistic hope of significant recovery (*initial your choice below*):

   _____ I do want tube feedings to be given.
   _____ I do not want tube feedings to be given.

2. If I designated a healthcare agent in Part I, I indicate below whether my healthcare agent must follow the instructions in this Part II if I am in an end-stage medical condition or am permanently unconscious (*initial your choice below*):

   _____ My healthcare agent must follow the instructions in this Part II.
   _____ My healthcare agent may use these instructions as guidance and override any instructions I have given in this Part II.

3. I indicate below whether I want to donate my organs and tissues at the time of my death for the purpose of transplant, medical study, or education (*initial your choice below*):

   _____ I consent to donate my organs or tissues.
   _____ I do not consent to donate my organs or tissues.

PART III: SIGNATURE

Pennsylvania law protects my healthcare agent and healthcare providers from any legal liability for their good faith actions in following my wishes as expressed in this document or in complying with my healthcare agent's direction. On behalf of myself, my executors, and heirs, I further hold my healthcare agent and my healthcare providers harmless and indemnify them against any claim for their good faith actions in recognizing my healthcare agent's authority or in following my treatment instructions.

Having carefully read this document, I have signed it this _____ day of _____, 20___, revoking all previous healthcare powers of attorney and living wills.

_____
(*Signature*)

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of the principal may not be a witness. It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your healthcare providers).

_____
(*Witness Signature*) (*Witness Printed Name*)

_____
(*Witness Signature*) (*Witness Printed Name*)

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 DEPARTMENT OF HEALTH

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)

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.