# DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

It is important to choose someone to make health care decisions for you when you cannot. **Tell the person you choose what you would want.** The person you choose has the same right as you do to make the decisions and to make sure your wishes are honored. If you **DO NOT** choose someone to make decisions for you, write **NONE** on the line for the agent's name.

I appoint the person named below to be my agent to make health care decisions for me when and only when I cannot make decisions or communicate what I want done. This is a **Durable Power of Attorney for Health Care Decisions** and the power of health care, including the power to direct the withholding or withdrawal of life-prolonging treatment. In exercising this power, I expect my agent to be guided by my directions as stated in my Health Care Decisions (See Page 2). Any costs should be paid from my own resources. I and my estate hold my agent and my caregivers harmless and protect them against any claim based upon following this Durable Power of Attorney for Health Care or my Health Care Decisions. My agent may not appoint anyone else to make decisions for me. My agent is also authorized to:

* Consent, refuse or withdraw consent for any care, treatment, service or procedure (including artificially supplied nutrition and/or hydration/tube feeding) used to maintain, diagnose or treat a physical or mental condition;
* Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home or other health care organization; to employ or discharge health care personnel (any person who is authorized or permitted by the laws of the state to provide health care services) as my agent shall deem necessary for my physical, mental and emotional well being;
* Request, receive and review any information regarding my personal affairs or physical or mental health, including medical and hospital records; and to execute any releases of other documents that may be required to obtain such information;
* Move me into or out of any state or institution for the purpose of complying with my Health Care Decisions or the decisions of my agent;
* Take legal action, if needed, to do what I have directed;
* Make decisions about autopsy and organ donation, and the disposition of my body;
* Become my guardian if one is needed.

**If you DO NOT want the person (agent) you name to be able to do any of the above things, draw a line through it, and put your initials at the end of the line.**

Agent's Name: ______________________________ Phone: ____________________

Address ____________________________________________________________

**If you do not want to name an alternate, write 'None.'**

First Alternate
Name ______________________________

Address ______________________________

Phone ______________________________

Second Alternate
Name ______________________________

Address ______________________________

Phone ______________________________

---

SIGN HERE for the Durable Power of Attorney and/or Health Care Decision forms. Many states require notarization. Please ask two (2) persons not related to you to witness your signature.

Signature ______________________________ Date: ____________________

Witness ____________________ Date __________ Witness ____________________ Date __________

**Notarization:**

On this ____ day of ______________ in the year of ___________, personally appeared before me the person signing, known by me to be the person who completed this document of his/her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County of ____________________, State of ___________

Notary Public ______________________________ Commission Expires ____________________



**Printed from www.southeastmissourihospital.com (Form posted December 2003)**

## HEALTH CARE DECISIONS/ADVANCE DIRECTIVE

*** TAKE A COPY OF THIS WITH YOU WHENEVER YOU GO THE HOSPITAL ***

I, ______________________________________, SS#_________________________ want everyone who cares for me to
(Please print)
know what health care I want when I cannot let others know what I want.

I always expect to be given care and treatment for pain or discomfort even when such care might shorten my life, make me feeling like not eating, slow down my breathing, or be habit-forming.

I want my doctor to try treatments that may get me back to an acceptable quality of life. By acceptable quality of life, I mean living in a way which lets me do the things that are important and necessary to me. Those things are:

_______________________________________________________________________________

_______________________________________________________________________________

Examples: the ability to:
*recognize family or friends *make decisions *communicate *feed myself *take care of myself

**If there is no reasonable hope that I will be able to understand or communicate.**
**I want these directions to be followed.**

I direct that no treatment be given just to keep me alive when I have
*a condition that will cause me to die soon, or
* a condition so bad (including substantial brain damage or brain disease) that it is not expected that I will regain a quality of life acceptable to me (as described above)

When I have one of the above conditions, the treatments **I DO NOT** want include:
*Surgery
*Doing things to start my heart or breathing, if either stops (CPR)
* Medicine to treat infections (antibiotics)
* Artificial kidney machine (dialysis)
* Breathing machine (respirator, ventilator)
* Food or water given through a tube in the vein, nose or stomach (tube feedings)
* Blood transfusions
* Other treatments

*** If you DO want one or more of the above treatments, circle it and initial at the end of the line ***

I want to donate my organs or tissues and realize it may be necessary to maintain my body artificially until my organs can be removed ( ) Yes ( ) No ( ) Undecided

My other directions include: ______________________________________________________________

_______________________________________________________________________________

Example: *hospice care * death at home, if possible * specific directions regarding organ donation

Talk about this form and your ideas about your health care with the person you have chosen to make decisions for you, your doctor(s), family, friends, and clergy, and give each of them a completed copy.

You may cancel or change this form at any time. You should review it every so often. Each time you review it, put your initials and the date here:
______________________________________________________

**Be sure to sign Page 1 of this form.**


Printed from www.southeastmissourihospital.com (Form posted December 2003)