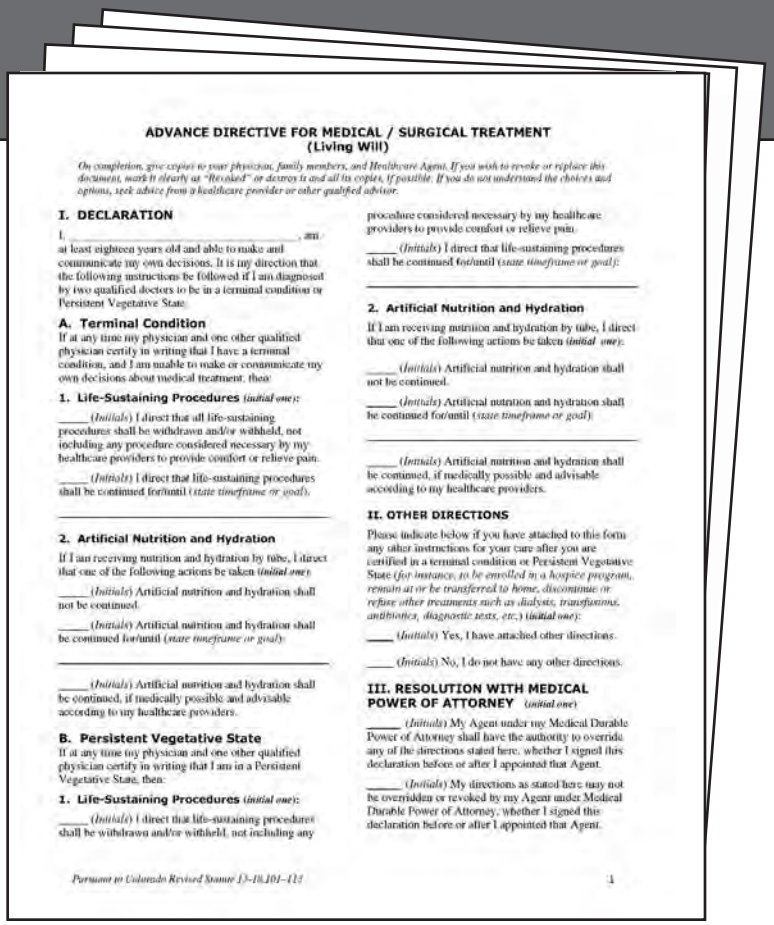
# MAKING HEALTH CARE DECISIONS

## Colorado Advance Directive Guide

KAISER PERMANENTE®

# COLORADO
# ADVANCE HEALTH CARE DIRECTIVE



**ADVANCE DIRECTIVE FOR MEDICAL / SURGICAL TREATMENT**
**(Living Will)**

*On completion, give copies to your physician, family members, and Healthcare Agent. If you wish to revoke or replace this document, mark it clearly as "Revoked" or destroy it and all its copies, if possible. If you do not understand the choices and options, seek advice from a healthcare provider or other qualified advisor.*

**I. DECLARATION**

I, _____, am at least eighteen years old and able to make and communicate my own decisions. It is my direction that the following instructions be followed if I am diagnosed by two qualified doctors to be in a terminal condition or Persistent Vegetative State.

**A. Terminal Condition**

If at any time my physician and one other qualified physician certify in writing that I have a terminal condition, and I am unable to make or communicate my own decisions about medical treatment, then:

**1. Life-Sustaining Procedures** *(initial one)*:

_____ *(Initials)* I direct that all life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____ *(Initials)* I direct that life-sustaining procedures shall be continued for/until *(state timeframe or goal)*:

_____

**2. Artificial Nutrition and Hydration**

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken *(initial one)*:

_____ *(Initials)* Artificial nutrition and hydration shall not be continued.

_____ *(Initials)* Artificial nutrition and hydration shall be continued for/until *(state timeframe or goal)*:

_____

_____ *(Initials)* Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

**B. Persistent Vegetative State**

If at any time my physician and one other qualified physician certify in writing that I am in a Persistent Vegetative State, then:

**1. Life-Sustaining Procedures** *(initial one)*:

_____ *(Initials)* I direct that life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

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_____ *(Initials)* Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

**II. OTHER DIRECTIONS**

Please indicate below if you have attached to this form any other instructions for your care after you are certified in a terminal condition or Persistent Vegetative State *(for instance, to be enrolled in a hospice program, remain at or be transferred to home, discontinue or refuse other treatments such as dialysis, transfusions, antibiotics, diagnostic tests, etc.)* *(initial one)*:

___ *(Initials)* Yes, I have attached other directions.

___ *(Initials)* No, I do not have any other directions.

**III. RESOLUTION WITH MEDICAL POWER OF ATTORNEY** *(initial one)*

_____ *(Initials)* My Agent under my Medical Durable Power of Attorney shall have the authority to override any of the directions stated here, whether I signed this declaration before or after I appointed that Agent.

_____ *(Initials)* My directions as stated here may not be overridden or revoked by my Agent under Medical Durable Power of Attorney, whether I signed this declaration before or after I appointed that Agent.

*Pursuant to Colorado Revised Statute 15-18.101–113*

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Give your loved ones peace of mind; make your wishes known now.

These forms let you communicate your health care wishes when you no longer can.

## Your Packet Includes:

# INTRODUCTION

## What are Advance Health Care Directives (AHCD)?

**Advance Directive—Express your wishes now**
If you are able, it is up to you to make all of your health care decisions. However, if you are unable or unwilling to make decisions, the law provides for you to designate someone to make decisions on your behalf.

**Advance Health Care Directives (or AHCD) are legal documents.**
They represent your convictions, values, attitudes and beliefs about health, illness, dying and death. These forms let you communicate your health care wishes when you no longer can. It provides direction for your family members and health care providers when critical decisions must be made on your behalf.
**By completing advance directives now, you can avoid confusion later.** Even though an advance directive is a legal document, you do not need to consult a lawyer to complete it.

**One AHCD form also lets you identify your health care agent—**the person(s) who will work with your doctors and others when you can't—to ensure that your health care decisions are honored.
You can also document your decision about medical treatment with an advance directive. Under Colorado law you have the right to accept or reject medical treatment—including artificial life support—either by speaking for yourself if you are able, or by authorizing someone else to make the decision on your behalf.

# Why do I need to choose a health care agent?

## Who can be your agent?

**Often, many family members are involved in medical decision-making.** Even when you write down and share your wishes with others close to you, occasionally people will disagree about the best path of action for you. This is why you need to select one person to help ensure that your wishes are honored and to make any additional health care decisions on your behalf.

**It is best to choose a close relative or personal friend who you trust**, who understands your values, and who will agree to honor your wishes. You can also name another person(s) to act in your behalf in the event the first person is no longer available or able to make decisions for you. These people are called the alternate or temporary agent(s). You can also indicate if you do not want a specific person(s) involved in making decisions for you.

If you are concerned and want to spare loved ones from the burden of decisionmaking, you may want to consider choosing a close family friend who understands your wishes to act as your agent.

## Agent Criteria

- **Your agent does not have to be an attorney.** Also, this person does not have to live in Colorado, although you may want to choose someone nearby.
- **Try to select an agent who is most likely to be comfortable executing your wishes.** Make your wishes known to him or her, as well as to everyone else who is likely to be close to you in such circumstances. This is especially important if you anticipate conflict.
- **If you do not have an advance directive and suddenly become ill, you can assign a temporary agent(s)** verbally to let the doctor know who you want to be your health care agent. Your verbal instruction is just as legal as a written one.

**Remember, if there is no one willing or available to make decisions on your behalf, a court appointed guardian who doesn't know your values and wishes may have to make critical decisions for you.**

## What types of decisions can my health care agent make?

**Your health care agent is your Medical Durable Power of Attorney.**

**Based on your expressed wishes, your health care agent can decide whether:**

- you get treatment aimed at making you as comfortable as possible, or treatments to make you live as long as possible
- you get a visit by a minister, chaplain, priest, rabbi, or other spiritual counselor
- you die at home or in the hospital
- to allow your natural death or request that you go on life support
- some or all of your organs are donated.

**Your agent can also:**

- request, consent to, or refuse an autopsy (which can specify the cause of death)
- decide what happens to your body, such as burial or cremation.

**Becoming your health care agent does not mean that this person assumes financial responsibility for you.**

## Proxy Decision Maker by Statute

**When advance directives are not made**

What if your loved one has not made advance directives and has not named a medical durable power of attorney to speak for him or her and is too sick to do so now?

Colorado has a process called Proxy Decision Maker by Statute. With this process, those who care about this person get together and choose one person (called a proxy) to speak for the loved one. To find the Proxy Decision Maker by Statute form go to: **ColoradoAdvanceDirectives.com/Proxy_form.pdf**

## What if I want to provide specific health care instructions that are not on an AHCD form?

You can write more detailed health care instructions on additional sheets of paper, or you can use the communication form, "My Health Care Choices," which was designed to help you clarify your wishes for your doctor and loved ones. (Page 19)

- Attach your instruction sheet(s) to any Advance Health Care Directive and write the number of pages you are attaching.
- Sign and date the attachments.
- Inform your agent(s) and doctor(s) about your specific health care instructions sheet(s) to ensure they understand your wishes.

## What kinds of advance directive forms do I need?

**Colorado recognizes 4 kinds of advance directives as legal documents:**

1. The Medical Durable Power of Attorney—**choosing a health care agent**
2. Advance Directive for Medical/Surgical Treatment (Living Will)
3. Cardiopulmonary Resuscitation (CPR) Directive—**deciding not to be resuscitated**

**Tool to summarize advance directives for chronically ill people**

4. The Colorado Medical Orders for Scope of Treatment (called "MOST")—creating orders to be followed in the hospital, nursing home, etc. You get this form from your doctor's office or online (as listed on page 10).

**The documents included in this booklet are:**

## How do I complete an Advance Directive?

**Part 1:** **Choose your health care agent.** This is your Medical Durable Power of Attorney. He or she will make medical decisions for you if you are too sick to make them yourself. You can also choose to have your designated health care agent make theses decisions even if you are able.

**Part 2:** **State your health care choices.** Specify how you want to be treated medically, including whether you want medical treatment to prolong life or not. *For additional information about the choices you might want to consider please go to members.kp.org and click on "Health Encyclopedia," then "Get health advice."*

**Part 3:** **Sign the form.** An advance directive form is not legal until you sign it.

## Signatures required for advance directives in Colorado

- Medical Durable Power of Attorney (MDPOA)- requires only your signature.
- MOST- requires your signature and your physician's (nurse practitioner's or physcian assistant's).
- Living Will-requires two witnesses.
- CPR-requires your signature and your physician's signature.

## What if I change my mind after completing my AHCD?

You can cancel, revoke or change your advance directive, including a living will, at any time.

- Simply destroy the document or sign a statement that you no longer want it or replace it with a revised version.
- Notify everyone who has a copy of the changes.
- Give Kaiser Permanente or your doctor a copy of the new form for your medical records.

## Signed. Witnessed. Effective. Guidelines for safekeeping of your advance directive.

- Keep the original in an unlocked place that's easy for you and the important people in your life to get to at any time.
- Make several copies for yourself. Give copies to your health care agent, your doctor or medical record department, and key family members and friends.
- Make a list of everyone who receives a copy.
- Keep a copy in your car's glove compartment.
- Take a copy with you if you are admitted to a hospital or nursing home.
- Review your documents at least once a year to be sure they still reflect your wishes.
- When you review, check to see if you need to change your health care agent choice. His or her circumstances may have changed.
- Take a copy when you travel. If you spend long periods of time in another state, find out if Colorado forms are legal there or if you need to complete other forms.
- If you live in an assisted living facility, then you may want to place your document in a page protector and let your caregivers know where you store the document, i.e. inside your kitchen cabinet.

# YOUR LIVING WILL— END OF LIFE CHOICES

## What is the purpose of a living will?

The living will tells your doctor to allow natural death by not using artificial life support measures. In Colorado, your living will does not go into effect unless **you** are unable to make your wishes known **and** two doctors agree in writing that you have a terminal condition (with no chance of recovery) or are in a persistent vegetative state.

## What treatments qualify as life support?

Life support treatments include:

- **Cardiopulmonary Resuscitation (CPR)**—attempting to restart heart and breathing when they stop.
- **Breathing machine or ventilator**—use of a machine to breathe for you when you cannot breathe on your own.
- **Dialysis**—using a machine to replace the natural function of the kidneys.
- **Feeding tube**—using a tube to provide fluids and food when you are no longer able to swallow.

Without these life support measures, natural death may occur more quickly.

*Additional information about these measures is available on* ***kp.org/AdvanceDirectives****.*

## Living will requirements

- In Colorado, two doctors must agree in writing that you have a terminal condition before your living will goes into effect.
- You need two witnesses—at least 21 years old and mentally competent.
  **Witnesses cannot be:**
  someone who would inherit money or property from you, or someone who provides health care for you or who works for an organization which provides your health care.
- A physician signature is not required.
- You do not need an attorney to complete the form.
- You may choose to have the form notarized but it is not required.
- The living will may be an individual form or one combined in other documents, ie. a HIPPA release, an organ donation form, or a Medical Power of Attorney.

# The CPR Directive—
# Your decision about resuscitation

## Why is a CPR Directive necessary if I have a living will?

Even if you have other types of advance directives, the use of a CPR Directive is recommended if you do not want an attempt made to restart your heart or breathing. It instructs emergency and health care personnel not to begin CPR (heart re-starting and mechanical breathing procedures) if you stop breathing or if your heart stops.

Health care personnel will start CPR, if they are not aware that you do not want it.

***A template for this information is found on page 23.***
***Other versions are acceptable.***

## Do I need a CPR bracelet or necklace?

A necklace or bracelet is strongly recommended. This jewelry helps identify that you have a CPR Directive. Please note that the cost of a bracelet or a necklace is not covered by Medicare or by your Kaiser Permanente insurance plan.

To order a bracelet or necklace **after your CPR Directive is signed** contact:

**Award and Sign**
Phone: **303-799-8979**
Toll Free: **1-800-772-8979**
Fax: **303-799-6716**
Email: **info@awardandsign.com**

Or other companies like, **Medic Alert at MedicAlert.com**, **1-888-633-4298** (toll free).

## How do I cancel my CPR directive if I change my mind?

A CPR Directive may be canceled at any time by the person who has signed it. This can be done by simply destroying the document and removing the necklace or bracelet.

# MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST)

## What is MOST?

MOST is a document summarizing life-sustaining treatments. You and your doctor or nurse practitioner or physician assistant **will fill it out**. Both you and your doctor or nurse practitioner or physician assistant **must sign it**. This form contains direct orders for your treatment, based on your medical conditions and wishes. It travels with you and is honored in any setting: hospice, assisted living, hospital, day surgery, nursing home, or at home.

**Note:** If you have advance directives already created, you will want to have a copy with you to refer to as you discuss the options and fill in the MOST form.

## Who uses MOST?

MOST is intended for use with people who have a very serious illness (advanced chronic or terminal illness) and are frequently being seen by their health care providers.

You must be 18 years or older to complete MOST.

## What else should I know?

- Your choices should be consistent with your advance directives.
- MOST does not address every situation that might be addressed in an Medical Durable Power of Attorney (MDPOA) or Living Will.
- MOST overrules prior instructions **only** when there is a direct conflict.
- You should regularly review, confirm and update your choices based on your changing conditions.
- Photocopies or electronic scans of the original are also valid.
- The MOST form is easily and quickly understood by you, your doctor, other health care providers, and emergency personnel.

A copy of the MOST form is not included in this booklet. Your doctor's office has these forms or you can go to **ColoradoAdvanceDirectives.com.**

## Hospice Care—
## **Comfort in your last days**

### What is hospice care?

Hospice is not a place; it is a philosophy of care. Hospice care serves people with incurable illnesses who are no longer actively seeking medical treatment. The focus of hospice care is to assist individuals to live each remaining day of their lives in the most comfortable ways possible.

Most people are cared for at home. However, hospice care goes beyond home services. If a person needs medical attention, he or she can receive hospice care in a hospital, nursing home or free-standing independent facility.
Hospice also provides support in various forms as needed by care givers. Teamwork is key to the hospice philosophy. Hospice physicians, nurses, and social workers coordinate services with the patient's primary physician.

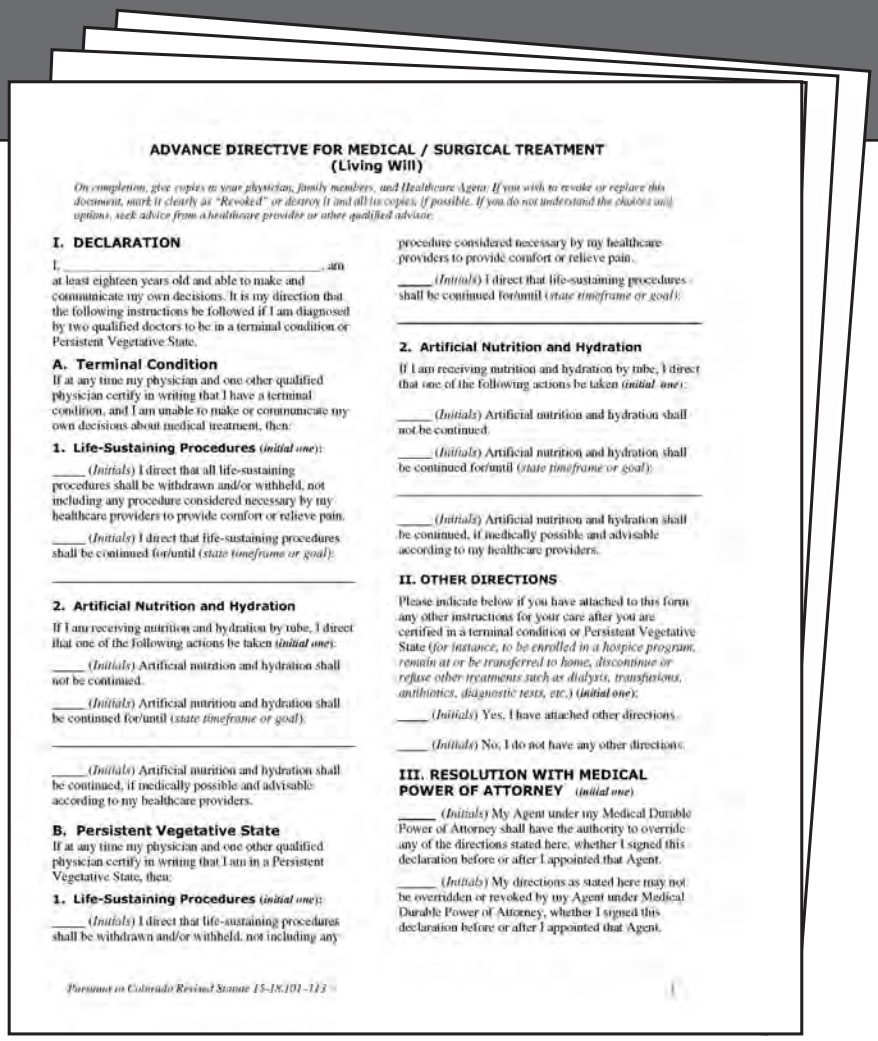
For more information about hospice care, please talk to your health care provider.

## Our promise—
## **Quality Care**

Our team of medical experts and health care professionals respect the rights of all patients. Whether you complete your advance directive or not, our goal is to provide compassionate, quality health care.

We support you in exercising your rights. If at any time you want information about our implementation policies, just ask. You can also document in your medical record whether or not you have completed an advance directive.

# COLORADO
# ADVANCE HEALTH CARE DIRECTIVE



**ADVANCE DIRECTIVE FOR MEDICAL / SURGICAL TREATMENT**
**(Living Will)**

*On completion, give copies to your physician, family members, and Healthcare Agent. If you wish to revoke or replace this document, mark it clearly as "Revoked" or destroy it and all its copies if possible. If you do not understand the choices and options, seek advice from a healthcare provider or other qualified advisor.*

**I. DECLARATION**

I, _____, am at least eighteen years old and able to make and communicate my own decisions. It is my direction that the following instructions be followed if I am diagnosed by two qualified doctors to be in a terminal condition or Persistent Vegetative State.

**A. Terminal Condition**

If at any time my physician and one other qualified physician certify in writing that I have a terminal condition, and I am unable to make or communicate my own decisions about medical treatment, then:

**1. Life-Sustaining Procedures** (*initial one*):

_____ (*Initials*) I direct that all life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____ (*Initials*) I direct that life-sustaining procedures shall be continued for/until (*state timeframe or goal*):

_____

**2. Artificial Nutrition and Hydration**

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (*initial one*):

_____ (*Initials*) Artificial nutrition and hydration shall not be continued.

_____ (*Initials*) Artificial nutrition and hydration shall be continued for/until (*state timeframe or goal*):

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**B. Persistent Vegetative State**

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**II. OTHER DIRECTIONS**

Please indicate below if you have attached to this form any other instructions for your care after you are certified in a terminal condition or Persistent Vegetative State (*for instance, to be enrolled in a hospice program, remain at or be transferred to home, discontinue or refuse other treatments such as dialysis, transfusions, antibiotics, diagnostic tests, etc.*) (*initial one*):

_____ (*Initials*) Yes, I have attached other directions.

_____ (*Initials*) No, I do not have any other directions.

**III. RESOLUTION WITH MEDICAL POWER OF ATTORNEY** (*initial one*)

_____ (*Initials*) My Agent under my Medical Durable Power of Attorney shall have the authority to override any of the directions stated here, whether I signed this declaration before or after I appointed that Agent.

_____ (*Initials*) My directions as stated here may not be overridden or revoked by my Agent under Medical Durable Power of Attorney, whether I signed this declaration before or after I appointed that Agent.

*Pursuant to Colorado Revised Statute 15-18.1(01-113*

## The Colorado Advance Directive forms:

# MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS

## I. APPOINTMENT OF AGENT AND ALTERNATES

I, _____,
Declarant, hereby appoint:

_____
*Name of Agent*

_____
*Agent's Best Contact Telephone Number*

_____
*Agent's email or alternative telephone number*

_____
*Agent's home address*

as my Agent to make and communicate my healthcare decisions when I cannot. This gives my Agent the power to consent to, or refuse, or stop any healthcare, treatment, service, or diagnostic procedure. My Agent also has the authority to talk with healthcare personnel, get information, and sign forms as necessary to carry out those decisions.

If the person named above is not available or is unable to continue as my Agent, then I appoint the following person(s) to serve in the order listed below.

_____
*Name of Alternate Agent #1*

_____
*Agent's Best Contact Telephone Number*

_____
*Agent's email or alternative telephone number*

_____
*Agent's home address*

_____
*Name of Alternate Agent #2*

_____
*Agent's Best Contact Telephone Number*

_____
*Agent's email or alternative telephone number*

_____
*Agent's home address*

## II. WHEN AGENT'S POWERS BEGIN

By this document, I intend to create a Medical Durable Power of Attorney which shall take effect either (***initial one***):

_____ (*Initials*) Immediately upon my signature.

_____ (*Initials*) When my physician or other qualified medical professional has determined that I am unable to make my or express my own decisions, and for as long as I am unable to make or express my own decisions.

## III. INSTRUCTIONS TO AGENT

My Agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way. If I have not expressed a choice about the decision or healthcare in question, my Agent shall base his or her decisions on what he or she, in consultation with my healthcare providers, determines is in my best interest. I also request that my Agent, to the extent possible, consult me on the decisions and make every effort to enable my understanding and find out my preferences.

*State here any desires concerning life-sustaining procedures, treatment, general care and services, including any special provisions or limitations:*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

My signature below indicates that I understand the purpose and effect of this document:

_____
*Signature of Declarant* *Date*

## ADDENDUM TO MEDICAL DURABLE POWER OF ATTORNEY – *RECOMMENDED, NOT REQUIRED*

### 1. Signature of the Appointed Agent

Although not required by Colorado law, my signature below indicates that I have been informed of my appointment as a Healthcare Agent under Medical Durable Power of Attorney for (*name of Declarant*)

_____.

I accept the responsibilities of that appointment, and I have discussed with the Declarant his or her wishes and preferences for medical care in the event that he or she cannot speak for him- or herself.

I understand that I am always to act in accordance with his or her wishes, not my own, and that I have full authority to speak with his or her healthcare providers, examine healthcare records, and sign documents in order to carry out those wishes. I also understand that my authority as a Healthcare Agent is only in effect when the Declarant is unable to make his or her own decisions and that it automatically expires at his or her death.

If I am an alternate Agent, I understand that my responsibilities and powers will only take effect if the primary Agent is unable or unwilling to serve.

_____
*Primary Agent's Signature*

_____
*Printed Name*

_____
*Date*

_____
*Alternate Agent #1 Signature*

_____
*Printed Name*

_____
*Date*

_____
*Alternate Agent #2 Signature*

_____
*Printed Name*

_____
*Date*

### 2. Signature of Witnesses and Notary

The signature of two witnesses and a notary seal are not required by Colorado law for proper execution of a Medical Durable Power of Attorney; however, they may make the document more acceptable in other states.

This document was signed by (*name of Declarant*)

_____

in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We declare that, at the time the Declarant signed this document, we believe that he or she was of sound mind and under no pressure or undue influence. We are at least eighteen (18) years old.

_____
*Signature of Witness*

_____
*Printed Name*

_____
*Address*

_____

_____
*Signature of Witness*

_____
*Printed Name*

_____
*Address*

_____

### Notary Seal (optional)

State of _____
County of _____ }
SUBSCRIBED and sworn to before me by

_____, the Declarant,

and _____

and _____

witnesses, as the voluntary act and deed of the Declarant this day of _____, 20____.

_____
Notary Public
My commission expires:_____

# ADVANCE DIRECTIVE FOR MEDICAL / SURGICAL TREATMENT
# (Living Will)

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_____ (*Initials*) My directions as stated here may not be overridden or revoked by my Agent under Medical Durable Power of Attorney, whether I signed this declaration before or after I appointed that Agent.

## IV. CONSULTATION WITH OTHER PERSONS

I authorize my healthcare providers to discuss my condition and care with the following persons, understanding that these persons are not empowered to make any decisions regarding my care, unless I have appointed them as my Healthcare Agents under Medical Durable Power of Attorney.

*Name* *Relationship*

_____

_____

_____

_____

_____

## V. NOTIFICATION OF OTHER PERSONS

Before withholding or withdrawal life-sustaining procedures, my healthcare providers shall make a reasonable effort to notify the following persons that I am in a terminal condition or Persistent Vegetative State. My healthcare providers have my permission to discuss my condition with these persons. I do NOT authorize these persons to make medical decisions on my behalf, unless I have appointed one or more of them as my Agent(s) under Medical Durable Power of Attorney.

*Name* *Telephone number or email*

_____

_____

_____

_____

_____

## VI. ANATOMICAL GIFTS

____ (*Initials*) I wish to donate my (*check one or both*)
____ organs and/or ____ tissues, if medically possible.

____ (*Initials*) I do not wish donate my organs or tissues.

## VII. SIGNATURE

I execute this declaration, as my free and voluntary act, this_____day of _____, 20____.

_____

*Declarant signature*

## VIII. DECLARATION OF WITNESSES

This declaration was signed by (*name of Declarant*)

_____

in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We declare that, at the time the Declarant signed this declaration, we believe that he or she was of sound mind and under no pressure or undue influence. We did not sign the Declarant's signature. We are not doctors or employees of the attending doctor or healthcare facility in which the Declarant is a patient. We are neither creditors nor heirs of the Declarant and have no claim against any portion of the Declarant's estate at the time this declaration was signed. We are at least eighteen (18) years old and under no pressure, undue influence, or otherwise disqualifying disability.

_____

*Signature of Witness*

_____

*Printed Name*

_____

*Address*

_____

_____

*Signature of Witness*

_____

*Printed Name*

_____

*Address*

_____

### Notary Seal (optional)

State of _____
County of _____ }

SUBSCRIBED and sworn to before me by

_____, the Declarant,

and _____

and _____

witnesses, as the voluntary act and deed of the Declarant this day of _____, 20____.

_____

Notary Public
My commission expires:_____

# MY HEALTH CARE CHOICES

Personal Health Care Instructions Communication Form

## I. How much I want to know about my condition:

*(Please mark statement 1 or 2.)*

- ❑ 1: I wish to know all relevant facts of my condition. I can cope better with what I know than with the unknown.
- ❑ 2: I do not wish to know all the details of my condition, especially if the news is bad. I fear that such knowledge will diminish my will to live and will cast a shadow over the time left to me. If there is bad news about my condition, I want my health care agent to take over making medical decisions for me, even if I still have mental capacity to make health care decisions.

## II. How strictly I want my agent to follow my instructions:

I am writing how I want health care decisions made. **I want my agent strictly to follow this document.** If other decisions come up that I have not made here, I want my agent to rely on other information he or she has about my wishes and my values.

Additional comments:

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

- ❑ at home.
- ❑ in the hospital.

Additional Instructions:

IV. Near the end of life, when would you want your doctors to consider allowing your disease to take its natural course? When is it time to allow a natural death? For example, which of these sentences do you most agree with: 1 or 2?

- ❑ 1: My life is only worth living if I can:

  *(Check all that apply; add more if you want.)*

  - ❑ talk to family or friends
  - ❑ communicate in some way with my loved ones
  - ❑ recover enough to feed, bathe, or take care of myself
  - ❑ be free from pain
  - ❑ live without being hooked up to machines
  - ❑ _____
  - ❑ I am not sure
- ❑ 2: My life is always worth living no matter how sick I am, even if I am unable to communicate at all and even if I won't get better.

V. If I am so sick that I may die soon:

- ❑ Any treatments that might work can be tried to see if they will arrest or cure my disease. Even if treatments are **unlikely to work** and there is little hope of getting better, **I want to stay on life support** machines.
- ❑ Any treatments can be tried to see if they will 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 and would want to die a more natural death, in comfort.
- ❑ If I am very sick and may die soon, I want everything done possible to make me comfortable.
- ❑ I have already decided that I do **not** want to have the following treatments, even if it means that I might die by not having them:
  - ❑ I want **no** attempts at CPR.
  - ❑ I want **no** breathing machine.
  - ❑ I want **no** dialysis.
  - ❑ I want **no** blood transfusion.
  - ❑ I want **no** artificial feeding and hydration.
  - ❑ I want **no** medicines of any kind unless they are provided for my comfort.
  - ❑ _____
  - ❑ **I do not want any life support** treatments at all, even if it means that I might die by not having them.



Initials: _____

## VI. Religion or spirituality is

❑ important to me

❑ unimportant to me

What my doctors should know about my religion or spirituality:

## VII. After my death

❑ I want to donate my organs. *Which organs do you want to donate?*

❑ any organs

❑ only the following organs _____

❑ I **do not** want to donate my organs.

❑ I want my **health care agent** to decide.

## VIII. What my agent and doctors should know about how I want my body to be treated after I die:

❑ I **do not** want an autopsy.

❑ I **want** an autopsy if there are questions about my death.

❑ I want my **health care agent** to decide about autopsy.

❑ My preferences about funeral/burial/cremation are_____

_____

_____.

❑ I want my **health care agent** to decide about burial or cremation.

Additional instructions:

Signature: _____ Date: _____

If you are completing this form at the same time as your Advance Health Care Directive, please remember to attach it so your signature can also be witnessed or verified by a notary public.

**Patient's or Authorized Agent's Directive to Withhold Cardiopulmonary Resuscitation (CPR)**
This template is consistent with rules adopted by the Colorado State Board of Health at 6 CCR 1015-2

## Patient's Information

Patient's Name_____
(Printed Name)

*If Applicable*- Name of Agent/Legally Authorized Guardian/Parent of Minor Child _____
(Printed Name)

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female Eye Color: _____ Hair Color: _____

Race Ethnicity : ☐ Asian or Pacific Islander ☐ Black, non-Hispanic ☐ White, non-Hispanic
☐ American Indian or Alaska Native ☐ Hispanic ☐ Other

*If Applicable*- Name of hospice program/provider: _____

## Physician's Information

Physician's Name: _____
(Printed Name)

Physician's Address: _____

Physician's telephone: ( ) _____ Physician's Colorado License #: _____

## Directive Attestation

Check **ONLY** the information that applies:

☐ Patient: I am over the age of 18 years, of sound mind and acting voluntarily. It is my desire to initiate this directive on my behalf. I have been advised that as a result of this directive, if my heart or breathing stops or malfunctions, I will not receive CPR and I may die.

☐ Authorized Agent/Legally Authorized Guardian/Parent of Minor Child: I am over the age of 18 years, of sound mind, and I am legally authorized to act on behalf of the patient named above in the issuance of this directive. I have been advised that as a result of this directive, if the patient's heart or breathing stops or malfunctions, the patient will not receive CPR and may die.

☐ Tissue Donation: I hereby make an anatomical gift, to be effective upon my death of:
☐ Any needed tissues
The following tissues: ☐ Skin ☐ Cornea ☐ Bone, related tissues and tendons

**I hereby direct emergency medical services personnel, health care providers, and any other person to withhold cardiopulmonary resuscitation in the event that my/the patient's heart or breathing stops or malfunctions. I understand that this directive does not constitute refusal of other medical interventions for my/the patient's care and comfort. If I/the patient am/is admitted to a health care facility, this directive shall be implemented as a physician's order, pending further physician's orders.**

_____ _____
☐ Signature of Patient
☐ Authorized Agent/Legally Authorized Guardian/Parent of Minor Child
Physician Signature

_____ _____
Date Date

# Keeping Track of My Advance Health Care Directive

Date of my Advance Health Care Directive (AHCD): _____.

Where I have put extra, easy-to-find copies of my AHCD:

_____

All the people and facilities to whom I have given copies of my AHCD:

name: _____ name: _____

address: _____ address: _____

_____ _____

phone: _____ phone: _____

(home, work, cell, and pager) (home, work, cell, and pager)

---

name: _____ name: _____

address: _____ address: _____

_____ _____

phone: _____ phone: _____

(home, work, cell, and pager) (home, work, cell, and pager)

---

name: _____ name: _____

address: _____ address: _____

_____ _____

phone: _____ phone: _____

(home, work, cell, and pager) (home, work, cell, and pager)

---

name: _____ name: _____

address: _____ address: _____

_____ _____

phone: _____ phone: _____

(home, work, cell, and pager) (home, work, cell, and pager)

---

Cut out and place in your wallet with your medical card.

**Important notice to medical personnel:**
I have a Colorado Advance Health Care Directive.

_____
Signature

In an emergency, please consult my health care agent(s):

_____
primary agent name

_____
address city / state / zip

_____
phone (cell, home) **see other side**

Fold

_____
alternate agent name

_____
address city / state / zip

_____
phone (cell, home)

My Advance Health Care Directive is located at:

_____

_____

_____

# Roles and responsibilities of the health care agent

The role of a **health care agent** may be one of the most important roles anyone can have. It is a way to fulfill a request made by a loved one to carry out their wishes about how they want to receive care when they are no longer able to express those wishes.

## How do I become a health care agent?

Health care agents are typically chosen when a person completes an **Advance Health Care Directive.**

The Advance Health Care Directive is a legal document which allows a person to document in advance the type of care they would or would not want, as well as identify someone 18 years or older who is close to them who has agreed to carry out their wishes at a time when they can no longer speak for themselves.

This person is called the “health care agent.” The terms “surrogate” or “proxy” are sometimes used in the place of “agent.” Surrogate, Proxy and Agent all mean the same thing.

The person completing the advance health care directive knows the health care agent well and trusts them to carry out their wishes and advocate on their behalf. The agent, therefore, should have a good understanding of their loved one’s values and treatment preferences beforehand so they are prepared to carry out their role as agent when that time comes. Becoming an agent **does not mean** that you assume financial responsibility for your loved one.

## As the health care agent, when would I start making health care decisions for my loved one?

On occasion, the agent may be asked to make health care decisions for a loved one even when that person is still capable of making his or her decisions. Most often, however, it is when your loved one is no longer able to make their own health care decisions.

Your role as the health care agent will be activated when care providers decide your loved one is too ill to participate in discussions about treatment options. When this decision is reached, the care providers will begin to rely on you to help determine the continued course of treatment for your loved one. However, when-or if-your loved one regains the ability to make their own decisions, your role as the agent may no longer be needed (or deactivated), and the health care team will again work with your loved one to make these decisions.

## How would I make health care decisions?

Your role as the health care agent will be to make decisions, in consultation with your loved one's care providers, based on what you know or how you feel your loved one would make them.

This is a very important responsibility. **Depending on how sick your loved one may be, you may be asked to make decisions that may include:**

- Your loved one's written statements regarding certain treatment options in their advance directive as well as conversations held with health care providers that are documented in their medical record.
- Conversations held with you or others regarding types of health care treatment they may or may not want, their values and spiritual preferences.
- Treatment decisions with the health care team on issues that may not be clearly covered by your loved one's written preferences in their advance directive, by documented conversations with health care providers or prior conversations with you and others close to them.

## What types of decisions will I be asked to make?

Your loved one's health care providers will be available to help you understand what is involved in any proposed treatment or procedure, as well as the risks or benefits and other options. Depending on how sick your loved one might be, you may be asked to make the following types of decisions. Your task as agent will be to make choices based on what your loved one would probably choose if he or she were well enough to make the decision, *even if it is not what you would choose for yourself*. These decisions may include:

- use of a breathing machine or ventilator. This is a machine that pumps air into the lungs and breathes for you when you can no longer breathe on your own.
- surgical operations or procedures
- starting, changing or stopping certain medications
- use of artificial nutrition and hydration when you can no longer swallow food
- blood transfusions
- use of CPR (cardiopulmonary resuscitation) to restart the heart
- use of a dialysis machine that cleans the blood when the kidneys are no longer working
- choosing or changing health care providers, arranging transfers to other health care facilities such as another hospital or nursing home
- contacting your loved one's minister, clergy, or other spiritual advisor for spiritual support
- deciding where your loved one spends their final days (at home, in the hospital, or elsewhere), donating organs/tissues, authorizing an autopsy, or making decisions about what will be done with the body.

# Where can I learn more about Advance Directives?

## Kaiser Permanente Services and Resources

- We offer a class called *It's Your Choice* that gives more information about advance care planning and completion of advance care documents. Call Health Education for details at **303-614-1010**.
- For online information and Advance Directive forms, log on to **kp.org/AdvanceDirectives.**
- For members in Colorado Springs, Memorial's HealthLink offers a class, "The Choice is Yours," at a 30 percent discount. Call **719-444-CARE** for information.

## Additional Resources

### Web sites

- Aging with Dignity **agingwithdignity.org**
- The National Hospice and Palliative Care Organization (NHPCO) **nhpco.org**
- Colorado Advance Directives Consortium **www.ColoradoAdvanceDirectives.com/contact.html**
- American Association of Retired Persons (AARP): **aarp.org**

## Organizations

- Colorado Senior Lobby: **303-832-4535**.
- American Bar Association: **1-800-285-2221 abanet.org**



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This information is not intended to diagnose health problems or to take the place of medical advice or care you receive from your physician or other health care professional. If you have persistent health problems, or if you have additional questions, please consult with your doctor.