CAPITAL REGION MEDICAL CENTER
Jefferson City, Missouri

HEALTH CARE DIRECTIONS

■ *Take a copy with you whenever you go to the hospital*

Name ______________________________

Address ______________________________

____

SS #________________ DOB ________________

I, ______________________________ (please print), want everyone who cares for me to know what health care I desire when I cannot communicate my wishes.

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

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

- The ability to recognize family and friends, feed myself, make decisions, take care of myself, or communicate.
- Other: ______________________________

____

I direct that the following treatment be given 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 there is no reasonable hope that I will regain a quality of life acceptable to me (as described above)**

Treatment	Do you want this?
• Surgery	☐ Yes ☐ No
• Doing things to try to start my heart or breathing, if either stops (CPR)	☐ Yes ☐ No
• Medicine to treat infections (antibiotics)	☐ Yes ☐ No
• Artificial kidney machine (dialysis)	☐ Yes ☐ No
• Breathing machine (respirator, ventilator)	☐ Yes ☐ No
• Food or water given through a tube in the vein, nose, stomach (tube feeding or IVs)	☐ Yes ☐ No
• Chemotherapy (cancer treatment)	☐ Yes ☐ No
• Blood Transfusion	☐ Yes ☐ No
• Other: ______________________________	☐ Yes ☐ No

If my doctor thinks that a treatment could help me recover, then I would like them to try that treatment.
If it does not help, I would like my doctor to stop the treatment even it that would cause me to die sooner.

My other directions include: (Examples: Hospice Care, death at home, etc.)

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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. Give each of them a completed copy. You may cancel or change this form at any time.

Signature: ______________________________ Date: ____________________

Witness: ______________________________ Date: ____________________

Witness: ______________________________ Date: ____________________

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 (agent) you choose what you would want. The person you choose has the same right as you do to make decisions and to make sure your wishes are honored. If you DONOT choose someone to make decisions for you, write NONE on the line for agent's name.

Name ____

Address ______________________________________

____

SS # __________________ DOB ________________

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 my agent shall not end if I become incapacitated or if there is uncertainty that I am dead. This revokes any prior Durable Power of Attorney for HealthCare Decisions. My agent may not appoint anyone else to make decisions for me. 1, 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 Directions. Any costs should be paid from my own resources. I grant to my agent full power to make all decisions for me about my 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 Directions (see reverse side). My agent is also authorized to:

- Consent, refuse or withdraw consent to 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; 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 or emotional wellbeing;
- Request, receive and review any information regarding my physical or mental health or my personal affairs 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 Directions or the decisions of my agent;
- Take any legal action, if needed, to do what I have directed;
- Make decisions about autopsy, 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 Agent
Name: ______________________________
Address: ____________________________
Telephone: __________________________

Second Alternate Agent
Name: ______________________________
Address: ____________________________
Telephone: __________________________

SIGN HERE for the Durable Power of Attorney

Durable Power of Attorney requires notarization.

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 and acknowledged it as 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______________________, the date written above.

Notary Public________________________________ My Commission Expires ____________________

Capital Region®
MEDICAL CENTER
An Affiliate of MU Health Care
Better. Every day.

Important Information to Complete Your Advance Directive

A conversation for you, your family & your physician

Part 1 - Health Care Directions

It is possible for any of us to experience a severe health problem suddenly or slowly. A time may come when a severe health problem is so bad that we might die from it. Or, we might not be able to return to an active quality of life. We all have personal feelings about what we want our doctors to do (or not to do) if that happens. *HEALTH CARE DIRECTIONS* give your doctors and family instructions about what treatments you would or would not want in a severe health situation.

Filling out the *HEALTH CARE DIRECTIONS form* is very important because it makes it clear to your doctors and family what to do if your health condition causes you not to be able to think or talk to them. The *HEALTH CARE DIRECTIONS form* lists specific treatments for you to check (√) YES (you want the treatment when you may be dying) or NO (you don't want that treatment when you may be dying).

It is a difficult time for our loved ones when we are severely sick and might be dying. Putting your wishes in writing on the *HEALTH CARE DIRECTIONS form* makes it much easier for loved ones at this difficult time. It is important to fill out this form while your health is stable or you are feeling well. The choices you make on the *HEALTH CARE DIRECTIONS form* can be changed at any time.

Part 2 - Durable Power of Attorney for Health Care Decisions (Agent)

It is important to think of a person that you love or trust to be your Durable Power of Attorney for Health Care Decisions. This person is called your Agent in legal terms. This identifies who you would want to make your health care decisions when you no longer can do so yourself. Be sure to discuss your health care wishes with them. Your Agent only makes your health care decisions when you cannot make them for yourself. Your *HEALTH CARE DIRECTIONS form* shows your wishes, and your Agent will make sure they are followed. **You must have 2 non-family witnesses and a notary present before you sign the form. A notary must watch you sign the form, so please do not sign it until your non-family witnesses and the notary arrive.**

Part 3 - Distribution of the Forms

When each of these forms is completed, make copies and give them to your doctor(s), your hospital(s), and your Agent. Keep the original for yourself.