

SPECIAL PURPOSE FORMS: PREHOSPITAL MEDICAL CARE DIRECTIVE and attachments for the LIVING WILL & HEALTH CARE POWER OF ATTORNEY

To complete any of the three attachments to the Living Will & Health Care Power of Attorney simply follow the instructions on the form. Give copies to whomever has a copy of your Living Will & Health Care Power of Attorney. If you want to prepare your own attachments or significantly modify the basic form or an attachment, it is advisable to consult with an attorney who is knowledgeable in this area.

Remember that the Prehospital Medical Care Directive (PMCD) form and card must be printed on orange colored stock.

Turn on bookmarks (second button from the left on the Acrobat Reader toolbar) to access the index to the forms and instructions in this file, or use the following links:

Prehospital Medical Care Directive (PMCD) Guidelines

PMCD form (2 masters to make two-sided page size form)

PMCD card (2 masters to make two-sided 23/8" x 41/4" size wallet card)

Attachments to Living Will & Health Care Power of Attorney:

Covering pregnancy

For disqualifying statutory surrogates

Refusing all LST because of current poor quality of life

GUIDELINES FOR USING THE *PREHOSPITAL MEDICAL CARE DIRECTIVE*

Note: The page size and wallet size forms that follow these instructions are for a one page orange form or card with printing on both sides. Make copies on orange stock for completion or complete on white paper and make orange copies of your original for distribution.

Step 1. Make certain the orange Prehospital Medical Care Directive is for you.

The *Prehospital Medical Care Directive* is used to direct emergency medical personnel not to administer cardiopulmonary resuscitation (CPR).

Use the orange form and card only if you do not want to be resuscitated at any time, under any circumstances.

The orange form is different from a Living Will. A Living Will typically directs that one be allowed to die *only* if conditions described in the document are met. The orange form contains *no* conditions. The “orange form” can prevent an Emergency Medical Technician (EMT) from using CPR to attempt to restore heartbeat and breathing regardless of the likelihood of a successful outcome. Any competent adult may complete an orange form; but, be certain you understand what it means before you do. Emergency personnel who are summoned will still perform needed comfort measures or emergency procedures other than CPR. This includes providing transport to a hospital where necessary and wanted by the patient.

Step 2. Select the versions of the orange form (page and/or wallet-card size) you will use; and, determine how many you need, and whether you will wear an orange band.

Immediate access is the key to effective use of the orange form. It should be with the person or prominently displayed in a place where it is certain to be found when needed. EMTs are accustomed to looking for a refrigerator for medication information. An uncluttered refrigerator door may be a good place for a copy. Bed-bound patients should have one placed in a visible location at their bedside. You may want to have more than one copy of the form in visible places. (Copies on orange paper are valid.) If you use the wallet-card size orange form, make sure it will be easy to find when opening your wallet or purse. You also may want to put a completed page-size form in your vehicle.

Will you wear the orange band? If you complete the form you may wear an orange hospital-type wrist or ankle band. It must have in bold type the words “DO NOT RESUSCITATE”, the patient’s name and the name of the patient’s physician. The band will only alert an EMT to look for the proper form. *If the orange form is not readily found, CPR will most likely be started.*

Step 3. Complete the form(s) you need.

Make certain that you complete all entries on the form.

The health care provider (any physician, osteopath, nurse, or physician assistant) who signs your Prehospital Medical Care Directive, preferably your doctor, will review it with you.

The completed documents must be dated and signed by you and signed by one witness.

If you need extra copies, print them on orange paper. The observations in Step 2 suggest having more than one completed form and band. In addition, a hospital stay may result in the loss of forms and bands. A form might be taken by emergency or admissions staff and not returned. Hospital staff would probably replace the orange PMCD band with the facility's band.

You may complete as many copies of the orange form as needed or make photocopies of an original. Photocopies printed on orange paper are legally valid, but the orange color of the original form makes it difficult to photocopy. However, setting a copy machine to produce the lightest possible copy may work.

Step 4. Prepare for the time of death.

Clients of hospice programs and some home care programs should have plans in place for what is to be done at the time of death and following death. If you do not already have a plan, consider the following in making yours:

Notify all interested persons that you have completed the orange form. Make sure they understand its purpose. "Interested persons" include your physicians, your health care agent, other members of your family and household, and, perhaps, friends and neighbors. While others may not need to have copies of the document, it is important that anyone who might be with you when you die knows where your Prehospital Medical Care Directive is kept and what you expect her or him to do.

Decide who is to be called at the time of death. "911" does not have to be called when an expected death occurs in the home. Work out this part of your plan with your physician, any in-home services you are using, and the organization that will handle the disposal of your body after death. Who will sign the death certificate if your physician cannot be available within the required time? Specifically ask what might happen to the body at the moment of death and how to prepare for and manage that.

People who chose to die at home can be organ and tissue donors. If you wish to be a donor, make arrangements to quickly have the body moved to the hospital where removal will take place. Advance arrangements are also normally required if the body is to be donated for medical research. Dorothy Garske Center has information on donating organs and donations for medical research.

Once your plan is worked out, write it down, and review it with those who are to implement it. Those who are to follow your written instructions must know where these and your advance directives are and be ready to do what is necessary.

Prehospital Medical Care Directive

(side one)

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient: _____ Date: _____
(Signature or mark)

Attach recent photograph here
or provide all of the following
information below:

Date of birth _____ Sex _____

Eye Color _____ Hair Color _____ Race _____

Hospice program (if any) _____

Name and telephone number of patient's physician:

{Note: A licensed health care provider and witness must sign on reverse. }

Prehospital Medical Care Directive

(Side two)

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

_____ Date _____
(Licensed health care provider)

I was present when this was signed (or marked). The patient then appeared to be of sound mind and free from duress.

_____ Date _____
(Witness)

[Note: This form is to be printed on two sides on orange paper.]

Prehospital Medical Care Directive

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient: _____ Date: _____
(Signature or mark)

Attach recent photograph here or provide all of the following information below:

Date of birth _____ Sex _____

Eye Color _____ Hair Color _____

Race _____

Hospice program (if any) _____

Name and telephone number of patient's physician:

A wallet card version of the Prehospital Medical Care Directive can be made using this and the following page. Print on orange card stock and complete both sides, or print on white paper, complete, and print copies on orange stock. Trim along dotted lines.

Prehospital Medical Care Directive

(Side two)

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

(Licensed health care provider signature)

Date _____

I was present when this was signed (or marked).
The patient then appeared to be of sound mind
and free from duress.

(Witness signature)

Date _____

ATTACHMENT
TO THE
LIVING WILL & HEALTH CARE POWER OF ATTORNEY OF

(Print your name)

MY WISHES SHOULD I BE PREGNANT WHEN MY DIRECTIVE IS IN EFFECT.

If I experience an unacceptable quality of life as indicated in section 7. of my Living Will & Health Care Power of Attorney dated _____ and I am pregnant, but I probably could be kept alive long enough for my fetus to mature sufficiently to be born healthy, *{Initial one statement; put a dash (-) at the other.}*

_____ then I would want my life sustained to try to accomplish that.

_____ I would want decisions about life-sustaining treatments to be made as if I were not pregnant.

Sign here in the presence of your witness.

Date

STATEMENT OF WITNESS: _____ is personally known to me, and I believe him/her to be of sound mind and to have voluntarily completed this directive. I affirm that I am at least 18 years old, not related to him/her by blood, marriage or adoption, and not an agent named in this directive. I am not, to my knowledge, a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

Witness signature

Date

Print witness name

Phone

Address

{If you complete this page, attach it to your Living Will & Health Care Power of Attorney.}

**ATTACHMENT TO THE
LIVING WILL & HEALTH CARE POWER OF ATTORNEY of**

{Print your name}

DISQUALIFICATION OF STATUTORY SURROGATES

If, because of illness or injury, I cannot make my own health care decisions, and my health care agent, if I have appointed one, is unable or unwilling to make health care decisions for me, then I **do not** want any of the following individuals to act as my health care surrogate: *{Check the classification(s) of surrogate(s) you wish to disqualify. In the space next to each classification you check, print the name or names of the individuals you want to disqualify. Classes of surrogates you do not disqualify, or individuals who would qualify as a member of a class but are not named, might be asked to make health care decisions for you, should you be unable to make your own decisions and your appointed agent(s) be unable or unwilling to serve. A.R.S. Section 36-3231}*

_____ Spouse* _____
_____ Adult child/children _____
_____ Parent(s) _____
_____ Domestic Partner _____
_____ Brother/sister _____
_____ Close friend _____

* If the patient and spouse are legally separated, the spouse does not qualify as a surrogate.

_____ Sign here in the presence of your witness.

_____ Date

STATEMENT OF WITNESS: _____ is personally known to me, and I believe him/her to be of sound mind and to have voluntarily completed this directive. I affirm that I am at least 18 years old, not related to him/her by blood, marriage or adoption, and not an agent named in this directive. I am not, to my knowledge, a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

_____ Witness signature

_____ Date

_____ Print witness name

_____ Phone

_____ Address

{If you complete this page, attach it to your Living Will & Health Care Power of Attorney.}

Statutory Surrogates Who Are Authorized Under Arizona Law To Make Health Care Decisions For Patients Who Are Unable To Make Such Decisions Personally.

Arizona law (*Arizona Revised Statutes section 36-3231*) provides that, under certain circumstances, persons, called surrogates have legal authority to make health care decisions for people who are unable to make their own health care decisions. This can be done for people who have not made a written health care directive or whose directive does not clearly apply in the particular circumstances when a health care decision must be made. The “surrogates” for those who have no agent or guardian for health care decisions that the law lists are as follows:

1. Your spouse, unless you are legally separated.
2. An adult child, or if there is more than one child, a majority of the adult children who are reasonably available.
3. A parent.
4. If no other person has assumed any financial responsibility for you, your domestic partner (if unmarried),.
5. A brother or sister.
6. A close friend, (someone who shows special concern for you, is familiar with your health care views, and is willing and able to serve as your surrogate).

Arizona law allows you to disqualify any of those people, if you do not want them to make health care decisions for you. If you want to disqualify certain people who might have authority to make health care decisions for you in the future, name these people on the reverse of this page and attach this page to your health care directive.

The law also allows you to disqualify your physician from being your surrogate. Your physician can make health care decisions for you if no other legally authorized person is available or willing to serve.

NOTE: If you appoint an agent in a Health Care Directive, the law provides that this person will be your surrogate as long as her or she is available and willing to serve. It probably is not necessary to disqualify surrogates if you have an agent.

**ATTACHMENT TO THE
LIVING WILL & HEALTH CARE POWER OF ATTORNEY of**

{Print your name}

**REFUSAL OF ALL LIFE-SUSTAINING TREATMENT BECAUSE OF
CURRENT POOR QUALITY OF LIFE**

Because of health losses I have experienced, I consider my quality of life to be unacceptable, or only marginally acceptable. For that reason, if I have or get a life-threatening condition (when I cannot make my own health care decisions) I want no life-sustaining treatment. Even if such treatment might completely reverse a life-threatening condition, I do not want it. *{Explain this choice here. If you need more space, use the reverse or attach additional pages and reference that you have done so here.}*

Sign here in the presence of your witness.

Date

STATEMENT OF WITNESS: _____ is personally known to me, and I believe him/her to be of sound mind and to have voluntarily completed this directive. I affirm that I am at least 18 years old, not related to him/her by blood, marriage or adoption, and not an agent named in this directive. I am not, to my knowledge, a beneficiary of his/her will or any codicil, and I have no claim against his/her estate. I am not directly involved in his/her health care.

Witness signature

Date

Print witness name

Phone

Address

{If you complete this page, attach it to your Living Will & Health Care Power of Attorney.}