

abridged
LIVING WILL & HEALTH CARE POWER OF ATTORNEY
form

Some home care patients and residents of long-term care facilities may not need or may not be able to complete the more thorough form presented in the consumer section of this web site.

We do not recommend the abridged form for anyone capable of completing the complete form available at this web site.

This form can be reproduced on two sides of a single page. It provides more useful information than does the statutory short form.

Written instructions to accompany this form are not presently available through the web site. The instructions for the unabridged version of this form are available in the PDF file INSTRUCTIONS covers the abridged form as well.

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HEALTH CARE POWER OF ATTORNEY AND LIVING WILL

of _____

(Print your name.)

If, because of illness or injury, I become personally unable to make health care decisions, I want all such decisions to be made for me by my health care agent if I have one. If I do not appoint an agent or none that I appoint is available, I want whoever is authorized by law to make health care decisions for me to follow this directive.

1. My healthcare agent: *{If you want to appoint a person to make healthcare decisions for you, complete this part, if you do not, cross out this section and go to section 2.}*

I appoint as my *agent* to make health care decisions for me, if I cannot make such decisions:

name: _____

address: _____

telephone: (work) _____ (home) _____

My alternate agent *{optional}*:

If my agent is unavailable or unwilling to act for me, then I name this *alternate agent*:

name: _____

address: _____

telephone: (work) _____ (home) _____

I give my agent *complete* authority to make decisions for me regarding my health care, including requesting medical treatments; consenting, refusing consent, and withdrawing consent already given, for medical treatment recommended by my physicians, including life-sustaining treatments; and, taking any other action necessary to do what I authorize and request in this document.

2. When I do not want life-sustaining treatment: *(Read both paragraph A and B. Initial the one that expresses your view. Put a dash (-) at the other.)*

_____ A. If I experience what I would consider an *unacceptable quality* of life because of illness or injury that probably cannot be reversed or from which I probably will not recover, and if I have or get a life-threatening condition, I do not want life-sustaining treatment. I consider the following *unacceptable qualities of life*:

- 1) Unconsciousness (persistent vegetative state or chronic coma); or,
- 2) Apparently or nearly complete loss of ability to think or communicate, even though not unconscious; or,
- 3) Total dependence on others for care, because of physical deterioration; or,
- 4) Pain that cannot be controlled without giving me so much medication that I cannot communicate verbally; or,
- 5) Another condition that my agent (or, whoever is authorized by law to make care decisions for me) determines that I would consider unacceptable quality of life.

(STOP. *{If you initialed paragraph A, do not initial paragraph B.}*)

_____ B. I have lived a long life and am ready to accept death when it comes. For that reason, if I have or get a life-threatening condition, I do not want life-sustaining treatment; even if treatment might completely reverse a life-threatening condition, I do not want it.

3. Life-sustaining treatments I do not want:

If I initial 2A and experience unacceptable quality of life, or if I initial 2B, I do not want these life-sustaining treatments started, and if already in use, I want them stopped: nutrition and hydration other than ordinary food and water delivered by mouth, if I cannot eat and drink enough to sustain me; all cardiopulmonary resuscitation measures to try to restart my heart and breathing if those stop; mechanical ventilation (breathing by machine); surgeries that prolong my life; blood dialysis or filtration to clean life-threatening substances from my blood, should my kidneys fail; transfusion of blood or blood products to replace lost or diseased blood; and medications when their purpose is to treat life-threatening conditions rather than control pain (for example, antibiotics, chemotherapy and insulin). *{You may eliminate any treatment listed above at the time you complete this directive by drawing a line through it. Initial and date each treatment you eliminate. Any treatments you eliminate might be used.}*

4. My wishes concerning pain medication:

If I appear to be in pain, I want enough medication to make me comfortable, even if my physician believes that might hasten my death or cause drug dependency. *{Initial your choice.}*

_____ Yes _____ No

5. My wishes concerning other matters: *{Initial your choices in a, and b. Item d. is optional.}*

- a. I want to donate organs/tissue: _____ Yes _____ No
- b. I consent to autopsy: _____ Yes _____ No
- c. If guardianship proceedings are instituted, and I named an agent in part I above, then I want that agent or alternate agent to be my guardian. I oppose appointment of anyone else, unless at the time of guardianship proceedings an agent I have appointed is not willing and able to serve.
- d. Other wishes: _____

6. How this directive can be revoked (canceled):

This directive can be revoked by an oral or written statement to that effect, or by any other expression of intention to revoke.

I understand what this document means. I make it of my own free will, and I have the mental and emotional capacity to do so.

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 name _____ Phone

Address