

Hospice LIVING WILL & HEALTH CARE POWER OF ATTORNEY form

The decision to enter hospice service should make it unnecessary to complete an advance directive. However, some hospice patient's want to use a directive to formally appoint an agent and to give specific treatment instructions. The Federal Patient Self-Determination Act requires that hospice patients be offered information about directives and asked if they have them. This has led to a fairly standard practice among hospice agencies of assisting patients who want to complete directives.

Dorothy Garske Center worked with hospice professionals to modify the basic Living Will & Health Care Power of Attorney form for use by hospice patients.

This form can be reproduced on two sides of a single page. It provides more useful information than does the statutory short form. *Suggested minimum donation for unrestricted use of the reproducible form and instructions is \$20.00.*

Written instructions to accompany this form are not presently available through the web site. A printed copy can be obtained through Dorothy Garske Center. The instructions for the unabridged version of this form are available in the PDF file INSTRUCTIONS covers the hospice directive form as well.

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HEALTH CARE POWER OF ATTORNEY AND LIVING WILL

of _____

(Print your name.)

I have a health condition that my physicians have told me will probably cause my death. Based on these opinions, I have chosen to enter a hospice program. However, if illness makes me 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 health care agent: *{If you want to appoint a person to make health care 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 consenting to medical treatment recommended by my physician, and directing my physician or other health care provider not to start or to stop life-sustaining procedures.

2. I do not want these life-sustaining treatments to be used to prevent my death:

{ 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. }

- a. Nutrition and hydration other than ordinary food and water delivered by mouth, if I cannot eat and drink enough to sustain me;
- b. All cardiopulmonary resuscitation measures to try to restart my heart and breathing if those stop;
- c. Mechanical ventilation (breathing by machine);
- d. Surgeries that prolong my life;
- e. blood dialysis or filtration to clean life- threatening substances from my blood, should my kidneys fail;
- f. Transfusion of blood or blood products to replace lost or diseased blood; and,
- g. Medications when their purpose is to treat life-threatening conditions rather than control pain (for example, antibiotics, chemotherapy and insulin).

