Advance Directives

Full Name_____

Address _____

Birthdate_____ Phone_____ Date _____

We recommend you keep an EASILY accessible copy; provide a copy to your medical decision-maker(s), family, physicians, local hospital; and file a copy with the Montana End of Life Registry.

DISCLAIMER: These documents are not a substitute for legal or medical advice. They are intended to help patients and their families with health care and end-of-life discussions and decisions. Future changes in the law are not predictable. Statements in these documents reflect laws in effect on the date drafted. Community use of these forms is encouraged.

PART 1
Durable Power of Attorney for Health Care

PART 2
Advance Care Planning & Treatment Preferences (Living Will)

PART 3
Additional Advance Care Planning Resources

PART 4
Montana POLST: Provider Orders for Life-sustaining Treatment
Medical orders for emergency care, signed by medical provider AND patient (or family).
Appropriate for elderly or people with serious illness.

LOGAN HEALTH

#608 12/22

PART 1: Durable Power of Attorney for Health Care

- Also called “health care agent,” or “surrogate” decision-maker. Valid for medical, NOT financial decisions (a separate financial POA is required for financial authority).
- Select someone who knows and respects your personal values and goals for medical treatment, and that you trust to make medical decisions on your behalf. That person should be readily available and able to advocate on your behalf.
- If a patient cannot or does not want to choose a POA, Montana law requires the medical decision-maker(s) to be assigned in the following SPECIFIC ORDER: court-appointed guardian; legal spouse; adult child or children (together); parents (together); sibling(s) (together); nearest other adult relative by blood or adoption.

I, _____ hereby appoint the following person(s) to act as my
(Patient Name)
agent(s) to make medical decisions for me:

Primary Agent

Name_____ Relationship_____

Address_____ Phone_____

City_____ State_____ Zip_____ Alternate Phone_____

If Primary Agent is unable or unavailable to make decisions at the time, then my Secondary Agent is:

Secondary Agent

Name_____ Relationship_____

Address_____ Phone_____

City_____ State_____ Zip_____ Alternate Phone_____

INITIAL ONE: I want my agent to make health care decisions for me:

_____ Effective immediately (although I still have the right to make decisions if I want and have the capacity to do so).

_____ Only when I cannot make health care decisions for myself (based on medical determination that I do not have such capacity).

Durable Power of Attorney for Health Care, continued

Full legal name (patient) _____

Address_____ City_____ State_____ Zip_____

Signature_____ Date_____

Witnesses cannot be the same as the agent noted on preceding page.

Witness #1 Signature_____

Printed name_____ Relationship_____

Address_____ City_____ State_____ Zip_____

Witness #2 Signature_____

Printed name_____ Relationship_____

Address_____ City_____ State_____ Zip_____

Notary (may be required outside of Montana)

STATE OF MONTANA
COUNTY OF _____

This instrument was acknowledged before me on this ____ day of _____, 20___

by _____.

_____
Notary Public for the State of Montana

Printed name of notary _____

Title or rank: _____

Residing at _____

My Commission Expires: _____

PART 2: Advance Care Planning — My Treatment Preferences

- Advance care planning is thinking about what health care you might want in the future. Completing an advance directive helps to tell your medical providers & family your medical wishes "in advance"—before you become too ill to speak for yourself.
- Open discussions with the people that matter to you, your medical decision-maker(s), and your medical providers are highly encouraged to ensure your wishes are understood. This clarity often provides loved-ones a sense of relief and less regret when having to make medical decisions on another's behalf.
- All people over 18 years of age are encouraged to complete Advance Directives.

What is important for your medical team to know about your life values and priorities, and how they relate to your medical care and choices? What does "living well" or having "a good day" look like to you?

What is important for you to still do in your remaining life?
(For example, certain milestones, activities, or amends)

Who are your support people? Who do you want involved in your medical care, or called if you are ill?
Is there anyone you specifically do NOT want involved in your medical care?

How does your spiritual background or faith influence your medical care? Would you like spiritual care support if you are ill? Specific requests:

When it comes to your medical care, which of the following is most important to you to maximize?

___Longevity: (how long you live or QUANTITY of life)

___Functional status (such as independence in activities of daily living, or being mentally alert)

___Comfort (QUALITY of life)

What does "quality of life" mean to YOU?

Signature_____ Date_____

My Treatment Preferences, continued

Do you wish to share in making decisions about your medical treatment, or do you prefer others to do so for you?

Would you always want to know the truth about your condition, treatment options, and expected chance of success of treatments? Please specify.

If your family wants medical treatment for YOU that is different from what YOU want for yourself, (initial one):

_____ Tell my family that I feel very strongly about these choices, and encourage them to respect and follow my wishes, as described in this document.

_____ It is okay to override my wishes, as my family (and/or doctors) will know best at that time.

When you are at the end of your life, what do you believe will be important to you?

_____ Being with loved ones _____Being in private

Pain control: (Initial one):

_____Try to balance pain relief and alertness

_____I prefer alertness, even if increased pain.

_____I prefer being as pain free as possible, even if I am sleepier due to medications.

Preferred location of care/death:

_____ Home _____Hospital _____Facility _____Other Location (specify):_____

Other anticipated hopes or fears?

Organ donation: (Initial):

_____I do NOT wish to donate my organs or tissue

_____I DO wish to donate my organs or tissue. (Specify any organ limitations.) (May require being maintained on life support until timing is right to donate organs.)

_____I wish to donate my body to science (specify any arrangements already made):

Cremation/burial, memorial service preferences:

Signature_____ Date_____

My Treatment Preferences, continued

If you are seriously ill, which of the following would you prefer regarding your level of medical care?

(Initial ONE):

_____Try all life support* treatments that my doctors think could help, with focus on life prolongation. Stay on life support treatments even if there is little hope of getting better.

_____Try life support* treatments that my doctors think could help, with attempt at life prolongation. Do NOT stay on life support treatments if they do not work, or if there is little hope of getting back to a life that aligns with my values.

_____Try noninvasive medical treatments ONLY; do not use invasive life support* treatments.

_____Use comfort focused treatments ONLY, with primary goal to maximize comfort, manage pain or other physical or emotional distress. Allow me to die naturally.

If I become:	I prefer (initial one choice per category)
Permanently unconscious: • I am in a coma and not aware of people or my surroundings • My doctors determine that I am unlikely to ever wake up from the coma.	_____No life support*/allow natural death _____Short term life support only _____Long-term life support _____Undecided
Permanently confused: • I cannot and will not be able to recognize my loved ones. • I am not able to make any health decisions.	_____No life support*/allow natural death _____Short term life support only _____Long-term life support _____Undecided
Dependent on others for all my care: • I am unable to talk or communicate clearly or move by myself. • Others must feed, toilet, bathe, and dress me every day.	_____No life support*/allow natural death _____Short term life support only _____Long-term life support _____Undecided
End stage illness: • I have an illness that has reached its final stages, despite treatment attempts.	_____No life support*/allow natural death _____Short term life support only _____Long-term life support _____Undecided

***Life-support,** also known as life- sustaining or life-prolonging treatments, includes the use of medical devices and treatments to keep a critically ill or injured patients alive in the intensive care unit. Includes "invasive" measures like cardiopulmonary resuscitation, mechanical ventilation, among others. These treatments do not generally cure the underlying medical conditions, but support the body until it either A) gets better from medical treatment or B) the life support is removed and the patient is allowed to die naturally.

Signature_____ Date_____

My Treatment Preferences, continued

Treatment	Definition	If medically indicated, I prefer: (initial one choice per category)
Blood products	Transferring blood or parts of blood from one person to another through the veins.	_____Want _____Do not want _____Try for a short time, stop if not improving
Intravenous (IV) fluid	Fluid that goes directly into the veins. Usually to help with dehydration	_____Want _____Do not want _____Try for a short time, stop if not improving
Artificial nutrition (feeding tube)	Nutrition given through tube directly into stomach or small intestine. Given either through a tube in the nose or through the abdominal wall into stomach.	_____Want _____Do not want _____Try for a short time, stop if not improving
Antibiotics or antiviral medications	Medications that treat bacterial or viral infections.	_____Want _____Do not want _____Try for a short time, stop if not improving
Chemotherapy or Radiation Therapy	Strong medications or radiation to slow cancer growth, or treat symptoms associated with cancer. May or may not cure the cancer.	_____Want _____Do not want _____Try for a short time, stop if not improving
Surgery	Performing an invasive operation inside the body.	_____Want _____Do not want _____Depends on the circumstances; defer to providers and/or my health care agent
Kidney dialysis	When kidneys have failed, a machine is used to remove & clean toxins from the blood; the blood is then returned to the body. Usually takes several hours of treatment several times per week.	_____Want _____Do not want _____Try for a short time, stop if not improving
Breathing tube & breathing machine (intubation & mechanical ventilator)	A machine provides breaths to the body when the body cannot sufficiently breathe on its own. This occurs through a tube inserted in the mouth, nose or neck. Usually requires sedation medication to tolerate. The person is usually unable to talk.	_____Want _____Do not want _____Try for a short time, stop if not improving (Medications would be used to help any sensation of breathlessness or air hunger, regardless of choice).
CPR (Cardiopulmonary Resuscitation)	A group of treatments when the heart and breathing have stopped (a person has died or cardiac arrest). Chest compressions are used to circulate blood through the body. Artificial breathing is required. Electrical shocks to the chest may be needed. Can be useful if a reversible condition, but unlikely to be successful in elderly or serious illness.	_____Want _____Do not want (Do NOT attempt resuscitation, abbreviated as DNAR or DNR) _____Try for a short time, stop if not improving

Signature_____ Date_____

PART 3: Additional Advance Care Planning Resources

Advance Directive Documents have been included in this packet for your use.
There are many other forms and educational resources available, with a few listed below.

ONLINE RESOURCES:

PREPARE for Your Care™. Online free resource to help people prepare for medical decision making. Features video stories to guide people as they explore their wishes and learn how to discuss with family and medical providers. The result is a 'Summary of My Wishes' document which can be shared. English and Spanish options. www.prepareforyourcare.org.

The Conversation Project, an initiative to help people talk about their end of life wishes. The Conversation Starter Kit is a useful tool to help you have "the conversation" with a family member or friend about your – and their— wishes regarding end-of-life care. Includes suggestions on how to choose or become a health care proxy, and how to talk to your doctor about end of life preferences and prognosis. Available in several languages.
https://theconversationproject.org/
https://theconversationproject.org/wp-content/uploads/2017/02/ConversationProject-TalkToYourDr-English.pdf

Tool Kit for Health Care Advance Planning, by the American Bar Association Commission on Law and Aging. Includes suggestions on how to pick a health care proxy. Provides many examples of decisions to be made and how to discuss with loved ones.
https://www.americanbar.org/content/dam/aba/administrative/law_aging/2020-tool-kit-hcap.pdf

The Stanford Letter Project. Free website with tools to help write letters about what matters to you, with real patient videos as examples. Available in several languages. http://med.stanford.edu/letter.

- The "What-Matters-Most" letter template—to write to your doctor about your care preferences.
- The "Who-Matters-Most" letter template—to complete a life review and write to loved ones.
- The "I-Matter-Too" or "Bucket List" tool---to help patients identify their life goals.

MyDirectives.com, a free web-based service that helps you create a digital advance care plan. Includes a smartphone app and options to record video statements. The directive can be stored in their secure database, available to you and your medical providers 24/7. https://mydirectives.com

Montana State University – Extension. Health Care Power of Attorney and Related Documents for Montanans.
https://store.msuextension.org/publications/FamilyFinancialManagement/EB0231ADA.pdf

Montana End of Life Registry & Advance Health Care Directives. Electronic storage for advance directives through Montana Office of Consumer Protection. Allows password protected access for registered consumers and health care providers. https://dojmt.gov/consumer/end-of-life-registry/

BOOKS:

Handbook for Mortals: Guidance for People Facing Serious Illness by Joanne Lynn, Joan Harrold, and Janice Lynch Schuster (2nd Ed., Oxford Univ. Press, 2011). 320-page guide for dealing with serious illness, with practical information about navigating the medical system and seeking physical care. Includes personal stories of how others approached illness and dying, including fear and spiritual needs. Available for purchase online or in book stores.

Hard Choices for Loving People: CPR, Artificial Feeding, Comfort Measures Only and the Elderly Patient by Hank Dunn. 80-page booklet on end-of- life decisions, including resuscitation, food and fluids, hospitalization, and curative versus comfort care. Available for purchase at www.hankdunn.com or Logan Health can provide a copy.