Advance Care Planning

A guidebook for patients and families

Memorial Health

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We recommend taking this guidebook to healthcare appointments and hospitalizations.

PATIENT INFORMATION

Name _____ Date of birth _____

Address _____

Phone number _____

Current POA/next of kin/family members _____

Current caregiver (if applicable) _____

Spiritual/cultural affiliation _____

Other pertinent documents and where to find them _____

_____

_____

Current medical problems or conditions _____

_____

_____

ADVANCE CARE PLAN SUMMARY

I completed this guidebook with _____

I have discussed my healthcare wishes with ○ POA-HC ○ Family ○ Physician

○ Others _____

My desired code status ○ Full code ○ DNR ○ Undecided

My goals of care ○ Living longer ○ Maintain current health ○ Comfort

ADVANCE DIRECTIVES

○ Power of Attorney ○ Living Will ○ POLST ○ Other _____

Location of advance directives _____

Planning for your future healthcare decisions is important.

This booklet will

1. Provide guidance in understanding your own values, beliefs and goals of care as they pertain to your current or future medical condition(s).
2. Offer direction in approaching the discussion with your family and loved ones.
3. Explain what an advance directive is.
4. Provide documents necessary to prepare and record your healthcare wishes.

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Introduction

Like many people, you may have put off having advance care planning discussions about your future healthcare treatment. Here are a couple situations to consider:

Carrie's Story

Carrie was **65 years old and had just retired.** She and her husband divorced about 15 years ago. Their twin boys were attending college when she was diagnosed with terminal lung cancer. Carrie had read about advance care planning, the importance of documenting her wishes and discussing them with family. She asked her doctor if it was time to take this step. When her doctor recommended hospice care, Carrie spent much time talking with her family about her wishes, what was important to her and what types of treatment she would accept. She completed her advance directive and filed the necessary paperwork with her healthcare provider. She did not want to burden her family with these decisions. When she grew too sick to direct her care, her twin boys knew exactly what their mother wanted, and honored her wishes.

Mary's Story

Mary was **85 years old. Her husband of 60 years passed away one year ago.** He had been her caregiver since she was diagnosed with Alzheimer's disease. Her health had declined since his death—she was forgetting to eat and take her medicine and her safety was at risk. But she still had good days where she was able to care for herself. She decided it was best that she go into a nursing home. There, the staff asked if she had a power of attorney for healthcare or an advance directive. Mary's parents had passed many years prior, as had her sisters, leaving her with no living family. The nursing home staff assisted Mary in completing her advance directive and encouraged her to name a Durable Power of Attorney for Healthcare. Luckily, Mary's longtime neighbor and friend felt comfortable assuming this responsibility. As the Alzheimer's progressed, Mary's friend was able to make decisions on her behalf. By documenting her wishes early, Mary avoided needing a court-appointed guardian.

Understanding Your Healthcare Wishes

What is important to me?

Identifying what is important in your life may seem overwhelming. Where do you begin? Use the following chart to help you identify some of the most important values related to your health and healthcare.

Take a few minutes to think about what is important to you.

IT IS IMPORTANT THAT I AM ABLE TO:	Level of Importance				
	Less				Very
Live as long as possible	1	2	3	4	5
Focus on my quality of life, rather than living a long time	1	2	3	4	5
Care for myself without assistance	1	2	3	4	5
Get out of bed (not be bedridden)	1	2	3	4	5
Move about independently	1	2	3	4	5
Recognize family and friends	1	2	3	4	5
Make my own decisions	1	2	3	4	5
Live in my home	1	2	3	4	5
Be free of chronic, severe pain	1	2	3	4	5
Live without long-term life support like breathing machines, feeding tubes or dialysis	1	2	3	4	5
Be financially independent	1	2	3	4	5
Leave a substantial estate to people or causes important to me	1	2	3	4	5
Live and die in keeping with my beliefs	1	2	3	4	5
Die naturally (without the use of machines or attempts at resuscitation)	1	2	3	4	5
Have spiritual peace	1	2	3	4	5

IF YOU **HAVE BEEN** PREVIOUSLY DIAGNOSED WITH A MEDICAL CONDITION, **START HERE:**

1. What is your understanding of your current medical condition(s)?

2. Have there been any changes with your medical condition(s) in the past few months?

3. Has your medical condition(s) interfered with your daily activities?

4. Based on your current understanding of your medical condition(s), what do you hope for with your current plan of care?

5. Have you been in the hospital recently because of your medical condition(s)? If yes, explain. (If no, continue to question 6.)

CONTINUE ON TO QUESTIONS 6–10

IF YOU **HAVE NOT BEEN** PREVIOUSLY DIAGNOSED WITH A MEDICAL CONDITION, **START HERE:**

6. What does "living well" mean to you? For example, if you were having a good day, what would you be doing? Who are you with?

7. What worries you most about your current or future medical condition(s)? What fears do you have?

8. What cultural beliefs do you have, if any?

9. What spiritual beliefs do you have, if any?

10. Express your values and beliefs in just a couple sentences:

Goals of Care Decisions

As you think about your current and future healthcare decisions, it is important to understand your options for care.

LEARN ABOUT LIFE-SUSTAINING TREATMENTS

The most common life-sustaining medical decisions involve:

Cardiopulmonary Resuscitation (CPR)

Do Not Resuscitate (DNR) Order

Artificial Nutrition and Hydration

What is Cardiopulmonary Resuscitation (CPR)?

CPR is the process of trying to restart the heart and pump blood to the body.
CPR is given when:

- Someone has stopped breathing, and the heart stops beating.
- Someone has a type of heartbeat that leads to no pulse and death.

WHAT CPR MIGHT INVOLVE:

- A CPR-trained individual pushes on your chest to try to start the heart again.
- A CPR-trained individual pushes air into your lungs.
- Electrical shocks may be given to the chest.
- If your heart restarts, but you cannot breathe on your own, you may be connected to a breathing machine called a ventilator.

WHAT IS A VENTILATOR?

A ventilator does the work of breathing for you if you are too sick to breathe on your own. You are connected to a breathing machine through a tube placed through your mouth into your windpipe. Medicines may be given to make you sleepy so there is less discomfort.

What is a Do Not Resuscitate (DNR) order

A DNR order prevents your healthcare team from initiating CPR. A physician may write a DNR order at your request, or at the request of your appointed healthcare agent. The DNR order must be signed by a doctor to be valid.

A DNR order only covers CPR. When you request a DNR order, he or she may also ask if you want a "do not intubate" order. Intubation is the placement of a tube in the nose or mouth to help you breathe when you cannot breathe adequately yourself. Intubation might prevent a heart attack or respiratory arrest.

Although CPR will not be given to a person who has a DNR order, the care team will take other steps to keep you as comfortable as possible.

What is medically administered nutrition?

Medically administered nutrition means giving liquid food and water to someone who is too sick to eat or drink on their own. This includes an IV line being placed in your vein or a feeding tube placed in your stomach.

Determining your priorities for medical care

Take some time to explore how your beliefs and values align with your priorities for medical care.

○ **LIVING LONGER**

- Live as long as possible, even if I do not know who I am or who I am with
- Be in the hospital and receive all care my doctors think will help me, even if it means relying on machines to keep me alive

○ **MAINTAINING CURRENT HEALTH**

- Live longer, if quality of life and comfort can be achieved
- Be in the hospital, if needed for effective care
- Stop treatment that does not work or makes me feel worse
- Allow a natural death if my heart or breathing stops

○ **COMFORT**

- Live the rest of my life focusing on my comfort and quality of life
- Avoid the hospital and being on machines
- Allow a natural death if my heart or breathing stops

Which of these priorities best matches what matters most to you?

Approaching Your Family

Now that you have explored your beliefs and values, and determined priorities for medical care, it is important to have a conversation about your healthcare wishes with your family and loved ones. This conversation can be difficult, but speaking with your family and loved ones about your wishes before a medical crisis occurs can give them a clear understanding of the future healthcare treatments you may want and not want.

Setting yourself up for the conversation

Who do you want to include in the discussion? Who do you want to be involved in your healthcare decisions?

Where would you prefer to have this conversation? And how? (e.g., phone call, in person)

Are there any relationships in your life that may impede progress of this conversation?

Are there any tasks you need to complete before having this conversation?

ICE BREAKERS: How do I get started?

Starting the conversation with your family can be difficult. Below are some conversation starters to consider using with your loved ones.

- **Medical condition:** Use your medical diagnosis to help start the conversation.

  "I want you to know my wishes so that you can communicate them for me, if my illness gets worse and I can't speak for myself."

- **Family experience:** Use an example of a family member's experience with serious illness and/or death to help loved ones know about your wishes.

  "Remember when _____ was on life support after having a heart attack..."

- **News example:** *"I read this article on end-of-life care, and it got me thinking about my wishes."*

- **Doctor recommendation:** *"My doctor provided me this booklet about care planning and suggested I talk about my wishes with you."*

You may be surprised at how your family reacts to the discussion. Remember, you are doing what is best to protect you and them. If you feel reluctant about having this discussion, you may also include another neutral party to assist in starting this conversation.

Approaching Your Healthcare Provider(s)

Next, it is important to let your healthcare provider(s) know about your healthcare wishes before a crisis occurs. Here are some things to keep in mind:

- Tell your healthcare provider(s) that you are completing your advance directives.
- Give your healthcare provider a copy of your completed directives.

QUESTIONS YOU MAY WISH TO ASK YOUR PHYSICIAN INCLUDE:

- ○ Will you talk openly with me and my family about my illness?
- ○ What decisions will my family and I have to make, and what kinds of recommendations will you give to help us make these decisions?
- ○ What will you do if I experience a lot of pain?
- ○ How will you help us find professionals with special training when we need them (e.g., medical, surgical and palliative care specialists, faith leaders, social workers, etc.)?
- ○ Will you let me know if treatment stops working so that my family and I can make appropriate decisions?
- ○ Will you still be available to me even when I am close to the end of my life?

Palliative Care: Supporting you through your serious illness

Palliative (pronounced pal-lee-uh-tiv) care is specialized care for people living with serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. At Memorial Health, our Palliative Care team is committed to improving quality of life for both the patient and the family.

Working in partnership with the patient's other providers, the Palliative Care team can help patients with serious illness and their families by:

- Ensuring that care is matched to goals and priorities
- Providing counseling and support
- Facilitating family meetings with the healthcare team
- Educating patients and families about what to expect in the future
- Communicating and coordinating with the healthcare team
- Recommending approaches for the management of physical and emotional symptoms
- Assisting with the identification of a surrogate decision-maker

Palliative care is based on the needs of the patient, not on the patient's diagnosis or prognosis and can be appropriate at any age or stage of serious illness.

HOW CAN I REQUEST PALLIATIVE CARE?

Ask your physician or another member from the medical team for a referral.
For more information, call Palliative Care at:

Decatur Memorial Hospital	**217–876–4691**
Jacksonville Memorial Hospital	**447–784–2914**
Springfield Memorial Hospital	**217–788–3484**
All other affiliates	**217–788–3360**

The Palliative Care service is available in the hospital and community-based settings.

Hospice care

As you near the end of your life, hospice care may be right for you.

WHAT IS HOSPICE CARE?

It is a specialized type of care for a person who is in the end stage of their life. Hospice focuses on managing a person's pain and other symptoms, so that they can live as comfortably as possible, and have the best quality of life possible, with the time that remains.

The goal of hospice care is comfort rather than cure: it aims to treat a person and their symptoms, rather than the disease itself.

Hospice focuses on the whole person: mental, spiritual and physical. Hospice is family-centered, providing services to assist the entire family through the end stages of their loved one's life.

HOW TO ACCESS HOSPICE CARE

If you are currently a patient in the hospital and would like more information about hospice care, ask a member of your hospital care team.

You do not have to be in the hospital to qualify for hospice care. Memorial Health offers hospice services through Memorial Home Hospice. If you are interested in receiving hospice information or setting up hospice care, call Memorial Home Hospice at 217–788–4663 or speak with your primary care provider.

Advance Directives

An advance directive is a legal document that outlines your wishes for medical treatment if you are unable to make decisions and communicate your wishes for yourself.

Commonly used advance directives

POWER OF ATTORNEY FOR HEALTHCARE (POA-HC)

- This is a legal document that allows you to choose someone to make all healthcare-related decisions for you in the event you are unable to, or do not wish to, make decisions for yourself.
- The person you appoint is called your "primary agent." Your agent should be someone who knows you well—someone who knows what is most important to you and what your wishes would be for medical treatment. Your agent should be someone who feels comfortable carrying out your healthcare wishes for you.
- You can name backup agents, called "successor agents," who can act as your POA-HC if your primary agent is unable to do so.
- Only one person can act as your healthcare agent at a time.
- The POA-HC document is valid from the time you sign it until your death, unless you specify a time limit or create a new POA-HC document.
- Your agent has the authority to make any and all healthcare decisions when you are unable to make decisions for yourself, unless you state specific instructions or limitations on your POA-HC document.
- The POA-HC document does not require a doctor's signature to be valid.

LIVING WILL

- A Living Will is a document that informs your loved ones, POA-HC and healthcare providers that you do not want life-prolonging or death-delaying treatment if you are suffering from an incurable or irreversible condition and death is imminent.
- It also allows you to outline your specific wishes regarding your medical care.
- This document serves as a piece of guidance to your loved ones and providers about your wishes for medical treatment at the end of your life, if you cannot communicate for yourself. It is not a medical order and is not as legally durable as a POA-HC document. If you are unable to speak for yourself, your POA-HC will be the appointed person to make decisions on your behalf about stopping life-prolonging treatment and starting comfort-focused treatment.

Practitioner Order for Life-Sustaining Treatment (POLST)

Please read the following information carefully prior to completing a POLST form.

- A POLST is not an advance directive. It is a **medical order** that is meant to be completed with a healthcare professional.
- The form requires **an authorized healthcare practitioner signature** in order to be valid. Once signed, it will be honored by all medical staff.
- A POLST form documents the types of treatments, especially life-sustaining treatments, a person would want at the end of life if they were seriously ill.
- It allows people who are **elderly, frail and/or seriously ill** to state whether or not they would want cardiopulmonary resuscitation if they went into cardiopulmonary arrest.
- Additionally, it allows a person to state their preferences for the level of treatment they would wish to receive if their medical condition were to decline.
- It travels with the person to ensure that treatment preferences are honored across all settings of care: home, hospital, doctor's office or nursing facility.

For more information about the POLST form, please see **POLSTIL.org** or **dph.illinois.gov**.

Storing Advance Directives and POLST Documents

It's important to keep your documents in a safe, easily accessible place. Make sure your loved ones know where to find them. Give photocopies of the documents to your medical power of attorney, and be sure your doctors and anyone else involved in your care have copies as well. This can include family members, close friends and clergy. Some hospitals also keep copies of patients' advance directives on file in case the need arises. When you are admitted to the hospital for a surgery or other care, bring a copy with you and ask that it be placed in your medical record.

The **Durable Power of Attorney for Healthcare**, **Living Will** and **POLST form** are available at the end of this booklet.

For questions or assistance about the use of any form, please contact your medical provider and/or attorney.

For individuals who cannot afford to hire an attorney, assistance with Power of Attorney for Healthcare may be available at Land of Lincoln Legal Aid. Additional information is available at **LincolnLegal.org**.

Advance Directives

Notice to the individual signing the power of attorney for healthcare

No one can predict when a serious illness or accident might occur. When it does, you may need someone else to speak or make healthcare decisions for you. If you plan now, you can increase the chances that the medical treatment you get will be the treatment you want.

In Illinois, you can choose someone to be your "healthcare agent." Your agent is the person you trust to make healthcare decisions for you if you are unable or do not want to make them yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of agent in writing. The written form is often called an "advance directive." You may use this form or another form, as long as it meets the legal requirements of Illinois. There are many written and online resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing your advance directive.

What Are The Things I Want My Healthcare Agent To Know?

The selection of your agent should be considered carefully, as your agent will have the ultimate decision-making authority once this document goes into effect, in most instances after you are no longer able to make your own decisions. While the goal is for your agent to make decisions in keeping with your preferences and in the majority of circumstances that is what happens, please know that the law does allow your agent to make decisions to direct or refuse healthcare interventions or withdraw treatment. Your agent will need to think about conversations you have had, your personality, and how you handled important healthcare issues in the past. Therefore, it is important to talk with your agent and your family about such things as:

(i) What is most important to you in your life?

(ii) How important is it to you to avoid pain and suffering?

(iii) If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?

(iv) Would you rather be at home or in a hospital for the last days or weeks of your life?

(v) Do you have religious, spiritual or cultural beliefs that you want your agent and others to consider?

(vi) Do you wish to make a significant contribution to medical science after your death through organ or whole body donation?

(vii) Do you have an existing advance directive, such as a living will, that contains your specific wishes about healthcare that is only delaying your death? If you have another advance directive, make sure to discuss with your agent the directive and the treatment decisions contained within that outline your preferences. Make sure that your agent agrees to honor the wishes expressed in your advance directive.

What Kind Of Decisions Can My Agent Make?

If there is ever a period of time when your physician determines that you cannot make your own healthcare decisions, or if you do not want to make your own decisions, some of the decisions your agent could make are to:

(i) talk with physicians and other healthcare providers about your condition.

(ii) see medical records and approve who else can see them.

(iii) give permission for medical tests, medicines, surgery or other treatments.

(iv) choose where you receive care and which physicians and others provide it.

(v) decide to accept, withdraw or decline treatments designed to keep you alive if you are near death or not likely to recover. You may choose to include guidelines and/or restrictions to your agent's authority.

(vi) agree or decline to donate your organs or your whole body if you have not already made this decision yourself. This could include donation for transplant, research and/or education. You should let your agent know whether

you are registered as a donor in the First Person Consent registry maintained by the Illinois Secretary of State or whether you have agreed to donate your whole body for medical research and/or education.

(vii) decide what to do with your remains after you have died, if you have not already made plans.

(viii) talk with your other loved ones to help come to a decision (but your designated agent will have the final say over your other loved ones).

Your agent is not automatically responsible for your healthcare expenses.

Whom Should I Choose To Be My Healthcare Agent?

You can pick a family member, but you do not have to. Your agent will have the responsibility to make medical treatment decisions, even if other people close to you might urge a different decision. The selection of your agent should be done carefully, as he or she will have ultimate decision-making authority for your treatment decisions once you are no longer able to voice your preferences. Choose a family member, friend or other person who:

(i) is at least 18 years old;

(ii) knows you well;

(iii) you trust to do what is best for you and is willing to carry out your wishes, even if he or she may not agree with your wishes;

(iv) would be comfortable talking with and questioning your physicians and other healthcare providers;

(v) would not be too upset to carry out your wishes if you became very sick; and

(vi) can be there for you when you need it and is willing to accept this important role.

What If My Agent Is Not Available Or Is Unwilling To Make Decisions For Me?

If the person who is your first choice is unable to carry out this role, then the second agent you chose will make the decisions; if your second agent is not available, then the third agent you chose will make the decisions. The second and third agents are called your successor agents and they function as back-up agents to your first-choice agent and may act only one at a time and in the order you list them.

What Will Happen If I Do Not Choose A Healthcare Agent?

If you become unable to make your own healthcare decisions and have not named an agent in writing, your physician and other healthcare providers will ask a family member, friend or guardian to make decisions for you. In Illinois, a law directs which of these individuals will be consulted. In that law, each of these individuals is called a “surrogate.”

There are reasons why you may want to name an agent rather than rely on a surrogate:

(i) The person or people listed by this law may not be who you would want to make decisions for you.

(ii) Some family members or friends might not be able or willing to make decisions as you would want them to.

(iii) Family members and friends may disagree with one another about the best decisions.

(iv) Under some circumstances, a surrogate may not be able to make the same kinds of decisions that an agent can make.

What If There Is No One Available Whom I Trust To Be My Agent?

In this situation, it is especially important to talk to your physician and other healthcare providers and create written guidance about what you want or do not want, in case you are ever critically ill and cannot express your own wishes. You can complete a living will. You can also write your wishes down and/or discuss them with your physician or other healthcare provider and ask him or her to write it down in your chart. You might also want to use written or online resources to guide you through this process.

What Do I Do With This Form Once I Complete It?

Follow these instructions after you have completed the form:

(i) Sign the form in front of a witness. See the form for a list of who can and cannot witness it.

(ii) Ask the witness to sign it, too.

(iii) There is no need to have the form notarized.

(iv) Give a copy to your agent and to each of your successor agents.

(v) Give another copy to your physician.

(vi) Take a copy with you when you go to the hospital.

(vii) Show it to your family and friends and others who care for you.

What If I Change My Mind?

You may change your mind at any time. If you do, tell someone who is at least 18 years old that you have changed your mind, and/or destroy your document and any copies. If you wish, fill out a new form and make sure everyone you gave the old form to has a copy of the new one, including, but not limited to, your agents and your physicians.

If you are concerned that you may revoke your power of attorney at a time when you may need it the most, you may initial the box at the end of the form to indicate that you would like a 30-day waiting period after you voice your intent to revoke your power of attorney. This means if your agent is making decisions for you during that time, your agent can continue to make decisions on your behalf. This election is purely optional, and you do not have to choose it. If you do not choose this option, you can change your mind and revoke the power of attorney at any time.

What If I Do Not Want To Use This Form?

In the event you do not want to use the Illinois statutory form provided here, any document you complete must be executed by you, designate an agent who is over 18 years of age and not prohibited from serving as your agent, and state the agent's powers, but it need not be witnessed or conform in any other respect to the statutory healthcare power.

If you have questions about the use of any form, you may want to consult your physician, other healthcare provider, and/or an attorney.

Memorial Health

POWER OF ATTORNEY FOR HEALTHCARE

THIS POWER OF ATTORNEY REVOKES ALL PREVIOUS POWERS OF ATTORNEY FOR HEALTHCARE.
(You must sign this form and a witness must also sign it before it is valid.)

My name *(print your full name)*: _____

My address: _____

I WANT THE FOLLOWING PERSON TO BE MY HEALTHCARE AGENT
(an agent is your personal representative under state and federal law):

Agent name: _____

Agent address: _____

Agent phone number: _____

Please check box if applicable ☐ If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as guardian.

SUCCESSOR HEALTHCARE AGENT(S) *(optional):*
If the agent I selected is unable or does not want to make healthcare decisions for me, then I request the person(s) I name below to be my successor healthcare agent(s). Only one person at a time can serve as my agent *(add another page if you want to add more successor agent names).*

Successor agent #1 name, address and phone number: _____

_____

Successor agent #2 name, address and phone number: _____

_____

MY AGENT CAN MAKE HEALTHCARE DECISIONS FOR ME, INCLUDING:

(i) Deciding to accept, withdraw or decline treatment for any physical or mental condition of mine, including life-and-death decisions.
(ii) Agreeing to admit me to or discharge me from any hospital, home or other institution, including a mental health facility.
(iii) Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.
(iv) Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue or whole body donation, autopsy, cremation and burial.

The above grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of healthcare, including withdrawal of nutrition and hydration and other life-sustaining measures.

I AUTHORIZE MY AGENT TO *(please check any one box):*

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. *(If no box is checked, then the box above shall be implemented.)* **OR**

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. Starting now, for the purpose of assisting me with my healthcare plans and decisions, my agent shall have complete access to my medical and mental health records, the authority to share them with others as needed, and the complete ability to communicate with my personal physician(s) and other healthcare providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself. **OR**

☐ Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life and your previously expressed wishes. Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or healthcare provider if you have any questions about these statements.

SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES *(optional):*

☐ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.

☐ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of healthcare. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically in this form.

My signature: _____

Today's date:_____

DELAYED REVOCATION

☐ I elect to delay revocation of this power of attorney for 30 days after I communicate my intent to revoke it.
☐ I elect for the revocation of this power of attorney to take effect immediately if I communicate my intent to revoke it.

HAVE YOUR WITNESS AGREE TO WHAT IS WRITTEN BELOW, AND THEN COMPLETE THE SIGNATURE PORTION:

I am at least 18 years old, and *(check one of the options below*):

☐ I saw the principal sign this document, or
☐ the principal told me that the signature or mark on the principal signature line is his or hers.

I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent or the successor agent(s) by blood, marriage or adoption. I am not the principal's physician, advanced practice registered nurse, dentist, podiatric physician, optometrist, psychologist or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the healthcare facility where the principal is a patient or resident.

Witness printed name: _____

Witness address: _____

Witness signature: _____

Today's date:_____

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LIVING WILL

I, _____ born on _____ wish to make it known to those who may be charged with my care that I desire that the moment of my death not be artificially postponed.

If I should have an incurable and irreversible injury, disease or illness that, in my attending physician's judgment, will lead to my imminent death, I direct that any procedures or treatments that would only prolong my dying be withheld or withdrawn. I ask that I be provided only those treatments that will, in my physician's judgment, contribute to my comfort.

In the event of my inability to personally give direction regarding to my care, it is my intention that this statement be honored by my family and my physicians as my legal right to refuse medical or surgical treatment. I understand and accept the consequence of my refusal.

Additional directives:

_____

_____

_____

Signed: _____

City, County and State of residence: _____

Date: _____

The declarant is personally known to me, and I believe him or her to be of sound mind. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he or she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant's signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.

Witness: _____ Date: _____

Witness: _____ Date: _____

POLST form

State of Illinois
Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients: *Use of this form is completely voluntary. If desired, have someone you trust with you when discussing a POLST form with a health care professional.* ***For health care providers:*** *Complete this form only after a conversation with the patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. With significant change in condition, new orders may need to be written.*

PATIENT INFORMATION. *For patients: Use of this form is completely voluntary.*

Patient Last Name	Patient First Name	MI

Date of Birth (mm/dd/yyyy)	Address (street/city/state/ZIP code)

A *Required to Select One*

ORDERS FOR PATIENT IN CARDIAC ARREST. Follow if patient has NO pulse.

☐ **YES CPR**: **Attempt cardiopulmonary resuscitation (CPR).** Utilize all indicated modalities per standard medical protocol. (Requires choosing **Full Treatment** in Section B.)	☐ **NO CPR: Do Not Attempt Resuscitation (DNAR).**

B *Section may be Left Blank*

ORDERS FOR PATIENT NOT IN CARDIAC ARREST. Follow if patient has a pulse. Maximizing comfort is a goal regardless of which treatment option is selected. (When no option selected, follow Full Treatment.)

☐ **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments.** Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.

☐ **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.

☐ **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death.** Use medication by any route as needed. Use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

C *Section may be Left Blank*

Additional Orders or Instructions. These orders are in addition to those above (e.g., withhold blood products; no dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]

D *Section may be Left Blank*

ORDERS FOR MEDICALLY ADMINISTERED NUTRITION. Offer food by mouth if tolerated. (When no selection made, provide standard of care.)

☐ Provide artificial nutrition and hydration by any means, including new or existing surgically-placed tubes.

☐ Trial period for artificial nutrition and hydration but NO surgically-placed tubes.

☐ No artificial nutrition or hydration desired.

E *Required*

Signature of Patient or Legal Representative. *(eSigned documents are valid.)*

X Printed Name ***(required)***	Date

Signature ***(required)*** *I have discussed treatment options and goals for care with a health care professional. If signing as legal representative, to the best of my knowledge and belief, the treatments selected are consistent with the patient's preferences.*

X

Relationship of Signee to Patient: ☐ Patient ☐ Parent of minor	☐ Agent under Power of Attorney for Health Care	☐ Health care surrogate decision maker (See Page 2 for priority list)

F *Required*

Qualified Health Care Practitioner. Physician, licensed resident (second year or higher), advanced practice nurse, or physician assistant. (eSigned documents are valid.)

X Printed Authorized Practitioner Name ***(required)***	Phone

Signature of Authorized Practitioner ***(required)*** *To the best of my knowledge and belief, these orders are consistent with the patient's medical condition and preferences.* **X**	Date ***(required)***

THIS PAGE IS OPTIONAL – use for informational purposes		
Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records a patient's wishes for medical treatment in their current state of health. The patient or patient representative and a health care provider should reassess and discuss interventions regularly to ensure treatments are meeting patient's care goals. This form can be changed to reflect new wishes at any time.
No form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows a person to document, in detail, future health care instructions and name a Legal Representative to speak on their behalf if they are unable to speak for themselves.

Advance Directives available for patient at time of this form completion			
☐ Power of Attorney for Health Care	☐ Living Will Declaration	☐ Declaration for Mental Health Treatment	☐ None Available

Health Care Professional Information	
Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- The completion of a POLST form is always voluntary, cannot be mandated, and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone consent by the patient or legal representative are acceptable.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of the original form is encouraged. Digital copies and photocopies, including faxes, on ANY COLOR paper are legal and valid.
- Forms with eSignatures are legal and valid.
- A qualified health care practitioner may be licensed in Illinois or the state where the patient is being treated.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g., ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying, or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid.
- Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult children
4. Parents
5. Adult siblings
6. Adult grandchildren
7. A close friend of the patient
8. The patient's guardian of the estate
9. The patient's temporary custodian appointed under subsection (2) of Section 2-10 of the Juvenile Court Act of 1987 if the court has entered an order granting such authority pursuant to subsection (12) of Section 2-10 of the Juvenile Court Act of 1987.

For more information, visit the IDPH Statement of Illinois law at http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996)
PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Memorial Health

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THE JOINT COMMISSION ACCREDITED AND LICENSED IN THE STATE OF ILLINOIS

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