Missouri Living Will, Durable Power of Attorney for Health Care, and Health Care Directive

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Durable Power of Attorney for Health Care,
and
Health Care Directive

FEDERAL LAW REQUIRES THAT WE
PROVIDE YOU WITH THE
INFORMATION IN THIS BOOKLET

Missouri Living Will

DECLARATION

I have the primary right to make my own decision concerning treatment that might unduly prolong the dying process. By this declaration I express to my physician, family and friends my intent. If I should have a terminal condition, it is my desire that my dying not be prolonged by administration of death-prolonging procedures. If my condition is terminal and I am unable to participate in decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw medical procedures that merely prolong the dying process and are not necessary to my comfort or to alleviate pain. It is not my intent to authorize affirmative or deliberate acts or omissions to shorten my life, but rather only to permit the natural process of dying.

Signed on this _____ day of _____, 20_____.

SIGNATURE:_____

PRINT NAME:_____

CITY, COUNTY & STATE OF RESIDENCE:

_____

The declarant is known to me, is eighteen years of age or older, of sound mind and voluntarily signed this document in my presence.

WITNESS SIGNATURE:_____

PRINT NAME:_____

ADDRESS:_____

_____

WITNESS SIGNATURE:_____

PRINT NAME:_____

ADDRESS:_____

_____

Missouri Durable Power of Attorney for Health Care

Read this form and instructions carefully before attempting to complete it. The form and instructions are distributed to you with the understanding that Fitzgibbon Hospital and its affiliated members are not rendering legal advice. The Durable Power of Attorney for Health Care is not the only way to express your desires regarding future medical care. If you do not understand this form or the instructions, or if you feel it does not meet your needs, you should consult a lawyer.

The Durable Power of Attorney for Health Care allows you to express your desires concerning your future health care. It allows you to appoint an "agent" to make health care decisions, if you are unable to do so.

Decide whether you want to complete this Durable Power of Attorney for Health Care. You may choose not to complete it.

If there is a statement with which you do not agree, you may change it and write in your initials.

General Instructions for Completing the DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Read the entire form before signing or initialing any part.

Discuss this form with your physician, family and close friends. Include anyone who may be asked to make decisions concerning your future health care if you are unable to do so.

Give a copy of this form to your family, close friends, physicians, lawyer, minister, or anyone that may be asked to make decisions concerning your health care if you are unable to do so.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

If you decide to complete the Durable Power of Attorney for Health Care, please fill in the blank spaces and place your initials in the boxes as appropriate.

This form has been prepared to comply with the "Durable Power of Attorney for Health Care Act" of Missouri.

1. Selection of Agent

Complete this section by inserting the name, address and telephone number of the person you choose as your "Agent."

It is suggested that only one Agent be named.

I appoint the following person as my Agent:

NAME:_____

ADDRESS:_____

_____

TELEPHONE:_____

2. Alternate Agent(s)

If you wish to name an alternate "Agent(s)," write the name, address and telephone number of the person or persons you would like to be your "Agent(s)" if the person you named in Section 1 is not available.

Only an Agent named by me may act under this Durable Power of Attorney. If any Agent resigns or is not able or available to make health care decisions for me, or if an Agent named by me is divorced from me or is my spouse and legally separated from me, I appoint the person(s) named (in the order named if more than one):

First Alternate Agent:

NAME:_____

ADDRESS:_____

_____

TELEPHONE:_____

Second Alternate Agent:

NAME:_____

ADDRESS:_____

_____

TELEPHONE:_____

This is a Durable Power of Attorney, and the authority of my Agent shall not terminate if I become disabled or incapacitated.

3. Effective Date and Durability

This Durable Power of Attorney is effective when two physicians decide and certify that you are incapacitated and unable to make and communicate a health care decision. Incapacitated means that you are no longer able to make decisions for yourself and it is time for your "Agent" to act.

If you want two (2) physicians to decide whether you are incapacitated, do not write anything in this Section.

If you want one (1) physician to decide whether you are incapacitated, complete the section below:

If you want one (1) physician, instead of two, to decide whether you are incapacitated, write your initials in the box to the right.

INITIALS

4. Agent's Powers

In this section, you decide whether or not your Agent can make decisions concerning the withholding or withdrawing of artificially-supplied nutrition and hydration (food and water). Please indicate your decision by writing your initials in the box to the right of the statement that is consistent with your wishes.

I grant to my Agent full authority to:

A. Give consent to, prohibit, or withdraw any type of health care, medical care, treatment or procedure, even if my death may result.

If you DO wish to authorize your Agent to direct a health care provider to withhold or withdraw artificially-supplied nutrition and hydration (including tube feeding of food and water), write your initials in the box to the right.

INITIALS

If you DO NOT wish to authorize your Agent to direct a health care provider to withhold or withdraw artificially-supplied nutrition and hydration (including tube feeding of food and water), write your initials in the box to the right.

INITIALS

B. Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home or other healthcare organization on my behalf, and to hire and fire medical personnel responsible for my care, as deemed necessary for my physical, mental or emotional well-being.

C. Move me into or out of any health care facility (even if against medical advice) to obtain compliance with the decisions of my Agent.

D. Take any other action necessary to do what I authorize here, including, but not limited to, granting any waiver or release from liability required by any health care provider, and taking any legal action at the expense of my estate to enforce this Durable Power of Attorney.

5. Agent's Financial Liability and Compensation

My Agent acting under this Durable Power of Attorney will incur no personal financial liability. My Agent shall not be entitled to compensation for services performed under this Durable Power of Attorney, but my Agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision hereof.

6. Relationship Between Health Care Directive and Durable Power of Attorney

If I have executed a Health Care Directive, I encourage my Agent to follow my wishes as expressed in the Directive in making decisions regarding life-prolonging procedures. However, I have confidence in my Agent's ability to make decisions in my best interest, and I authorize my Agent to make decisions which are contrary to my Directive in his or her best judgment.

7. Protection of Third Parties Who Rely on My Agent

No person who relies in good faith upon any representations by my Agent or Alternate Agent shall be liable to me, my estate, my heirs or assigns, for recognizing the Agent's authority.

8. Revocation of Prior Durable Power of Attorney

If I have appointed an Agent in a prior Durable Power of Attorney, I revoke any health care terms contained in that Durable Power of Attorney.

9. Validity

This document is intended to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others. A copy of this document shall be as valid as the original.

You Must Sign this Document in the Presence of Two Witnesses and a Notary Public

To complete the Durable Power of Attorney, you must sign and date it in the presence of two (2) witnesses who are at least eighteen (18) years of age, and in the presence of a notary public.

In Witness Whereof, I have executed this **Durable Power of Attorney for Health Care** this _____ day of _____, 20_____.

SIGNATURE:_____

PRINT NAME:_____

The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses is at least eighteen (18) years of age.

WITNESS SIGNATURE:_____

PRINT NAME:_____

ADDRESS:_____

_____

WITNESS SIGNATURE:_____

PRINT NAME:_____

ADDRESS:_____

_____

State of Missouri)
) ss.
County of _____)

On this _____ day of _____, 20_____, before me personally appeared _____, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

In Witness Whereof, I have hereunto set my hand and affixed my official seal in the County of _____, State of Missouri, the day and year first above written.

NOTARY PUBLIC SIGNATURE:_____

My commission expires_____

REVOCATION
Durable Power of Attorney for Health Care

You may revoke this Durable Power of Attorney (DPOA) for Health Care at any time by completing this section. If, at any time, you want to revoke this Durable Power of Attorney for Health Care, complete the revocation below. Sign and date this revocation and have two witnesses sign and write in their addresses on the lines provided.

I hereby revoke the DPOA for Health Care dated _____.

SIGNATURE:_____

PRINT NAME:_____

DATE OF REVOCATION:_____

The person who signed this revocation is of sound mind and voluntarily signed this revocation in our presence. Each of the undersigned witnesses is at least eighteen (18) years of age.

WITNESS SIGNATURE:_____

PRINT NAME:_____

ADDRESS:_____

_____

WITNESS SIGNATURE:_____

PRINT NAME:_____

ADDRESS:_____

_____

Missouri
Health Care Directive

Read this form and instructions carefully before attempting to complete it. The form and instructions are distributed to you with the understanding that Fitzgibbon Hospital and its affiliated members are not rendering legal advice. The Health Care Directive is not the only way to express your desires regarding future medical care. If you do not understand this form or the instructions, or if you feel it does not meet your needs, you should consult a lawyer.

The Health Care Directive allows you to express your desires concerning your future health care.

The Health Care Directive allows you to furnish clear and convincing evidence of your intentions relating to the withholding or withdrawing of life-prolonging procedures, and may be relied upon by your physician, even if you are unable to communicate your decision.

Decide whether you want to complete this Health Care Directive. You may choose not to complete it.

If there is a statement with which you do not agree, you may change it and write in your initials.

General Instructions for Completing the HEALTH CARE DIRECTIVE

Read the entire form before signing or initialing any part.

Discuss this form with your physician, family and close friends. Include anyone who may be asked to make decisions concerning your future health care if you are unable to do so.

Give a copy of this form to your family, close friends, physicians, lawyer, minister, or anyone that may be asked to make decisions concerning your health care if you are unable to do so.

HEALTH CARE DIRECTIVE

If you decide to complete the Health Care Directive, please follow the instructions below.

Read the Directive carefully. Review the list of life-prolonging procedures and decide which, if any, of these procedures you would like to have withheld or withdrawn. Mark the appropriate box following each.

If I develop any incurable, progressive or degenerative disease stated to be terminal with respect to outcome (not with respect to time) and no cure is available and treatment only prolongs dying, I request that my physician follow my guide regarding life support and life-sustaining intervention(s) listed below. If my desires are not known and life-sustaining or life support procedures are utilized in an emergency situation, I request that my desires be respected and followed once they are known to my professional care team. I do not want to be kept alive in a vegetative state.

	I do want	I do NOT want	I WANT TRIED but stopped if I do not improve	I am UNDECIDED
Pacemaker - Any device that substitutes for the normal heart beat	☐	☐	☐	☐
Peritoneal Dialysis or Kidney Dialysis - Alternate means of filtering poisons from the body when the kidneys fail	☐	☐	☐	☐
Respirator - A breathing machine attached to a tube inserted into the lungs through the nose or mouth	☐	☐	☐	☐
Cardiopulmonary Resuscitation (CPR) - Intervention given by man, machine or drugs when the heart and/or lungs stop working	☐	☐	☐	☐
Feeding Tube for Food or Fluids - A tube placed into the stomach or bowel to give fluid and/or nutrition	☐	☐	☐	☐
Intravenous (IV) - Tubes for feeding and hydration	☐	☐	☐	☐
Antibiotics - To treat pneumonia or any other infection	☐	☐	☐	☐

	I do want	I do NOT want	I WANT TRIED but stopped if I do not improve	I am UNDECIDED
Cancer Therapy or Radiation - X-ray treatments for tumors or cancers	☐	☐	☐	☐
Chemotherapy - Cancer medicine given by mouth or intravenously	☐	☐	☐	☐
Transfusion - Blood or blood products given into a vein	☐	☐	☐	☐
Medical Treatment, Diagnostic Procedures and Tests - Further tests and procedures to monitor failing condition	☐	☐	☐	☐
Surgery - An operation only if it provides for my comfort and dignity	☐	☐	☐	☐
Uniform Gift Act, organ transplant - Donation of body parts Please specify:	☐	☐	☐	☐
Autopsy - Complete autopsy or selective autopsy to confirm my diagnosis	☐	☐	☐	☐
Research Consent	☐	☐	☐	☐

Other Concerns or Corrections:_____

_____

_____

I wish:

1. Caring and supportive nursing and medical care to relieve pain and suffering including narcotics to relieve pain even if respiration is depressed.

2. Food and fluids to be offered as long as I am conscious to take them by mouth and then moist sponges to moisten my lips to relieve the sensation of dehydration.

Validity

This document is intended to be valid in any jurisdiction in which it is presented. The provisions of this document are separable, so that the invalidity of one or more provisions shall not affect any others. A copy of this document shall be as valid as the original.

You Must Sign this Document in the Presence of Two Witnesses

Sign and date the Health Care Directive in the space provided. Have two witnesses sign and write in their addresses on the lines provided.

IN WITNESS WHEREOF, I have executed this document this _____ day of _____, 20_____.

SIGNATURE:_____

PRINT NAME:_____

The person who signed this document is of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses is at least eighteen (18) years of age.

WITNESS SIGNATURE:_____

PRINT NAME:_____

ADDRESS:_____

_____

WITNESS SIGNATURE:_____

PRINT NAME:_____

ADDRESS:_____

_____

REVOCATION
Health Care Directive

You may revoke this Health Care Directive at any time by completing this section. If, at any time, you want to revoke this Health Care Directive, complete the revocation below. Sign and date this revocation and have two witnesses sign and write in their addresses on the lines provided.

I hereby revoke the Health Care Directive dated _____.

SIGNATURE:_____

PRINT NAME:_____

DATE OF REVOCATION:_____

The person who signed this revocation is of sound mind and voluntarily signed this revocation in our presence. Each of the undersigned witnesses is at least eighteen (18) years of age.

WITNESS SIGNATURE:_____

PRINT NAME:_____

ADDRESS:_____

_____

WITNESS SIGNATURE:_____

PRINT NAME:_____

ADDRESS:_____

_____