Advance Directives

Living wills and other advance directives describe your preferences regarding your medical care. Because unexpected situations can happen at any age, all adults need advance directives. They describe your preferences regarding treatment if you're faced with a serious accident or illness. These legal documents speak for you when you're not able to speak for yourself. Choosing a person to act as your health care agent is possibly the most important part of your planning.

Please inform us if you have any of the following Advance Directives in place:

☐ **Living will.** This written, legal document spells out the types of medical treatments and life-sustaining measures you want and don't want, such as mechanical breathing (ventilation), tube feeding or resuscitation. A living will can't cover every possible situation.

☐ **Medical or health care power of attorney (POA).** The medical POA is a legal document that designates an individual — referred to as your health care agent or proxy— to make medical decisions for you in the event that you're unable to do so.

☐ **Do not resuscitate (DNR) order**. This is a request to not have cardiopulmonary resuscitation (CPR) if your heart stops or if you stop breathing.

☐ **Physicians Orders for Life-Sustaining Treatment (POLST)** is a form that gives seriously-ill patients more control over their end-of-life care, including medical treatment, extraordinary measures (such as a ventilator or feeding tube) and CPR.   http://capolst.org

☐ **Five Wishes Program** –http://www.agingwithdignity.org/
 Lets your family and doctors know:
 • Who you want to make health care decisions for you when you can't make them.
 • The kind of medical treatment you want or don't want.
 • How comfortable you want to be.
 • How you want people to treat you.
 • What you want your loved ones to know.

Power of Attorney for Health Care: I designate the following individual as my agent to make health care decisions for me:

Name _____ Relationship_____
Home Phone_____ Mobile Phone_____ Work Phone_____

Other health care instructions:

_____

Signatures:

 Name:_____

 Signature:_____

 Date:_____