Part I. Durable Power of Attorney for Health Care Choices

PRINT YOUR NAME

PRINT YOUR AGENT'S NAME AND ADDRESS

I, _____, appoint

Name: _____

Address: _____

as my agent for health care choices when I am unable to make decisions or communicate my wishes. In the case the person above cannot serve as my agent, or if I am divorced from or legally separated from the agent above, I appoint the person below:

PRINT YOUR ALTERNATE AGENT'S NAME AND ADDRESS

Name: _____

Address: _____

This alternate agent may make health care decisions for me when I am unable to do so or to communicate my wishes.

This durable power of attorney becomes effective when two physicians certify that I am incapacitated and unable to make and communicate health care choices.

INITIAL HERE IF YOU WANT TO ALLOW ONLY ONE PHYSICIAN TO DETERMINE WHETHER YOU ARE INCAPACITATED

You may choose to have one physician, instead of two, determine whether you are incapacitated. If you want to exercise this option — allowing one physician to determine whether you are incapacitated — initial here. _____

By completing this durable power of attorney, I authorize my agent to make all decisions for me regarding my health care. This includes the power to:

IF YOU DON'T WANT YOUR AGENT TO HAVE ANY OF THESE POWERS DRAW A LINE THROUGH THE PROVISION AND INITIAL NEXT TO IT

- Consent, refuse or withdraw consent to artificially supplied nutrition and hydration.
- Make all necessary arrangements for health care on my behalf. This includes admitting me to any hospital, psychiatric treatment facility, hospice, nursing home or other health care facility.
- Hire or fire health care personnel on my behalf.
- Request, receive and review my medical and hospital records.
- Take legal action if necessary to do what I have directed.
- Carry out my wishes regarding autopsy and organ donation, and decide what should be done with my body.

YOUR AGENT MAY HAVE A CLAIM AGAINST YOUR ESTATE FOR REASONABLE EXPENSES THAT ARE PART OF YOUR CARE

My agent under this durable power of attorney will not incur any personal financial liability. The agent also should not be compensated for services performed for me. However, the agent shall be reimbursed for reasonable expenses that are part of my care.

THIS IS A DURABLE POWER OF ATTORNEY AND THE AUTHORITY OF MY ATTORNEY IN FACT, WHEN EFFECTIVE, SHALL NOT TERMINATE OR BE VOID OR VOIDABLE IF I AM OR BECOME DISABLED OR INCAPACITATED OR IN THE EVENT OF LATER UNCERTAINTY AS TO WHETHER I AM DEAD OR ALIVE.

Part II. Health Care Choices Directive

I want those involved in my health care to understand my wishes if I cannot communicate or make decisions on my own. I make this directive to provide clear and convincing proof of my wishes and instructions about my health care and treatment. If my doctor believes medical treatment will lead to my recovery, I want to have the treatment. I also want to have care and treatment for pain or discomfort even if this treatment might shorten my life, affect my appetite, slow my breathing or be habit-forming.

If I have a terminal illness or condition and there is no reasonable hope I will recover, or if I am persistently unconscious, I direct all of the life-prolonging procedures I have initialed below to be withheld or withdrawn. I direct the following treatments to be withheld or withdrawn: (initial all that apply)

INITIAL ALL TREATMENTS THAT YOU WANT TO BE WITHHELD OR WITHDRAWN IN THE EVENT YOU ARE TERMINALLY ILL OR PERMANENTLY UNCONSCIOUS

_____ Surgery or other invasive procedures

_____ Cardiopulmonary resuscitation (CPR) to restart my heart or breathing

_____ Antibiotics

_____ Dialysis

_____ Mechanical ventilator (respirator)

_____ Artificially supplied nutrition and hydration (including tube feeding)

_____ Chemotherapy

_____ Radiation therapy

_____ All other “life-prolonging” medical treatments or surgeries that are merely intended to keep me alive without reasonable hope of making me better or curing my illness or injury.

Organ Donation Choices (initial only one)

INITIAL YOUR ORGAN DONATION PREFERENCE

_____ I consent to the donation of my organs or tissues. I realize my body may need to be maintained artificially after my death until my organs can be removed.

_____ I refuse to make anatomical gifts of part or all of my body. I prohibit my agent from consenting to such gifts before or after my death.

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

OPTIONAL DESCRIBE YOUR IDEA OF AN ACCEPTABLE QUALITY OF LIFE

I also give the following directions regarding my health care:

_____

_____

_____

_____

_____

_____

Attach extra pages if necessary. Sign and date the attached pages.

Optional: Describe what you consider an acceptable quality of life. For example, being able to recognize my loved ones, make decisions, communicate or feed yourself.

_____

_____

_____

_____

_____

_____

Attach extra pages if necessary. Sign and date the attached pages.

Make sure to talk about this directive and your wishes with your agent, your doctors, family, friends and clergy. Give each of them a copy of the directive. Bring a copy with you when you go to a hospital or other health care facility. Keep the original with your important papers.

Part III. Relationship Between Health Care Choices Directive and Durable Power of Attorney for Health Care Choices

This Part is effective only if I have completed Part I and Part II.

As I have executed the health care choices directive and durable power of attorney for health care choices, I trust and encourage my agent to:

- First, follow my wishes as expressed in the directive or otherwise from knowledge about me or having had discussions with me about making choices regarding life-prolonging medical treatment.

- Second, if my agent does not know my wishes for a specific decision, but my agent has evidence of what I might want, my agent can try to figure out how I would decide. This is called substituted judgment and requires my agent imagining himself or herself in my position. My agent should consider my values, religious beliefs, past choices and past statements I have made. The aim is to choose as I probably would choose, even if it is not what my agent would choose for himself or herself.

- Third, if my agent has very little or no knowledge of what I would want, then my agent and the doctors will have to make a decision based on what a reasonable person in the same situation would decide. This is called making decisions in my best interest. I have confidence in my agent's ability to make decisions in my best interest if my agent does not have enough information to follow my preferences or use substituted judgment, and if this is the case, I authorize my agent to make decisions that might even be contrary to my directive in his or her best judgment.

- Finally, if the durable power of attorney for health care choices is determined to be ineffective, or if my agent is unable to serve, the health care choices directive is intended to be used on its own as firm instructions to my health care providers regarding life-prolonging procedures.

THIS PART DESCRIBES THE RELATIONSHIP BETWEEN PARTS I AND II IN THE EVENT YOU FILL OUT BOTH PARTS

IF YOU DISAGREE WITH THIS RELATIONSHIP, YOU MAY WANT TO ONLY FILL OUT ONE PART OR TALK TO AN ATTORNEY ABOUT AN ADVANCE DIRECTIVE TAILORED TO YOUR NEEDS

Part IV. Execution

DATE YOUR DOCUMENT

IN WITNESS THEREOF, I have executed this document on this ____ day of _____, in the year of _____.

SIGN HERE AND PRINT YOUR NAME AND ADDRESS

Signature: _____
Print name: _____
Address: _____

If you filled out Part II, you must have your signature witnessed by two people who are at least 18 years of age.

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 18 years of age.

IF YOU FILLED OUT PART II, YOUR WITNESSES MUST SIGN AND PRINT THEIR NAMES AND ADDRESSES HERE

Witness #1
Signature: _____
Print name: _____
Address: _____

Witness #2
Signature: _____
Print name: _____
Address: _____

If you filled out Part I, you must have your advance directive notarized.

A NOTARY MUST FILL OUT THIS SECTION IF YOU FILLED OUT PART I

STATE OF MISSOURI)
) SS
COUNTY OF _____)

On this ____ day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed.

NOTE: YOU MUST HAVE YOUR DOCUMENT BOTH NOTARIZED AND SIGNED BY TWO WITNESSES IF YOU FILLED OUT PARTS I AND II

IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the County

of_____, State of Missouri, the day and year first above written.

_____ _____
Notary public's signature Notary seal

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your Missouri Advance Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. You may also want to save a copy of your form in Google Health, or another online medical records management service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning. You can read more about Google Health at http://www.caringinfo.org/googlehealth.

5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

6. Remember, you can always revoke your Missouri document.

7. Be aware that your Missouri document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called “prehospital medical care directives” or “do not resuscitate orders” are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**