(Place MR Label Here)
MR#:
Patient's Name:
Patient's Date of Birth:

UAMS Medical Center

## What are Advance Medical Directives?

Advance Medical Directives are written wishes about your future medical care. People usually just call them Advance Directives. There are 2 main types of directives:

1. **Durable Power of Attorney for Healthcare**
   A Durable Power of Attorney for Health Care is a document that names a person who will make medical decisions for you if you cannot make decisions for yourself.
2. **Living Will**
   If you cannot make decisions yourself, a Living Will tells your doctors and caregivers what you want. It keeps them from having to guess about your wishes.

**Important!** If you can make your own decisions, your doctors will ask you what you want even if you have Advance Directives. **Advance Directives are used only if your health problems become so bad that you cannot make your own decisions.**

## Who should have Advance Directives?

Everyone should have Advance Directives. Life-threatening health problems, accidents, and illnesses can happen to anyone at any time. Advance Directives help "direct" others to follow your wishes about the kinds of care you do and do not want when you cannot make decisions yourself.

## How do I set up my Advance Directives?

1. **Choose who you want to make medical decisions for you if you cannot.**
   This person you choose is called your Health Care Agent. Pick someone who can best talk about your wishes when you cannot. You can name a first choice and a second choice. If your first choice is not able to make decisions for you, your second choice will be asked to.
2. **Fill out Form 1 – My Durable Power of Attorney for Healthcare: This forms lets you name the people you want to make medical decisions for you if you cannot.**
   - **Step 1: Pick your healthcare agent**
     - ✓ Name who you want to be your first choice. Put down their contact info.
     - ✓ If you want to add a second choice, name them and include their contact info.
     - ✓ Sign and date the form.
   - **Step 2: Finalize the Document**
     - ✓ Have 2 witnesses sign the form, **or** have the form notarized.
     - ✓ You do not need to notarize the form if you have witnesses sign it.
3. **Learn about end-of-life treatments**
   Think about the following treatments that might be used to keep you alive. Ask your doctor or any medical staff for more information. Decide if you would want these to be started at all, or if you want these to be stopped at a certain time if you are not getting better.

- **Cardiopulmonary Resuscitation** (CPR): Restarting your heart and lungs when they have stopped working. It can include pushing on your chest, using electrical shock to start your heart, and pumping air into your lungs.
- **Breathing machines** (Ventilators): Using a machine to help you breathe or to breathe for you if you cannot on your own. If you need one, you will often need a tube down your throat or a hole in your neck.
- **Dialysis**: Using a machine to clean your blood when your kidneys stop working.
- **Artificial Nutrition**: Giving you food or liquid by putting a tube in your nose or belly (feeding tube), or by giving it to you in a vein, when you cannot swallow.

4. **Fill out Form 2 – My Living Will:** This form tells your doctors and caregivers what you want if you cannot make the decision yourself.

   **Step 1: Check one box for this section**
   - ✓ Pick what option you want if you become so sick that you are likely to die soon.
   - ✓ If you have specific wishes for this situation, then choose the last box and write in anything you do or do not want to happen.

   **Step 2: Check one box for this section**
   - ✓ Pick what option you want if you have a severe brain injury and your doctors do not think you will recover enough to be aware of and interact with those around you.
   - ✓ Severe brain injuries are things like comas you will not recover from, being in what doctors call a persistent vegetative state, or being in the end-stages of dementia.
   - ✓ If you have specific wishes for this situation, choose the last box and write in anything you do or do not want to happen.

   **Step 3: Write down any other wishes you have**
   - ✓ Write down anything else you would like to tell your doctors, family, or caregivers.
   - ✓ You are not limited here. You can write in types of treatments you want or do not want – or you can write in anything else you'd like people to know.
   - ✓ Sign the document.

   **Step 4: Finalize the Document**
   - ✓ Have 2 witnesses sign the form, **or** have the form notarized.
   - ✓ You do not need to notarize the form if you have witnesses sign the form.

5. **Tell your loved ones about your Advance Directives**
   - Tell your Health Care Agent (your first choice and second choice, if you have one) that you have listed them on these forms. Give them a copy. Let them know why you do or do not want certain treatments.
   - Talk about these forms and give copies to family and friends who might be called in an emergency. Also give a copy to your doctors to be put in your medical records.

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**Print your name here:** _____

**Your birth date**: _____

# My Durable Power of Attorney for Healthcare


## Choose who you want to make medical decisions for you if you cannot (this person is called your healthcare agent)

**My first choice:**

✓ We will ask this person first if you cannot make medical decisions for yourself.

_____
First Name Last Name

_____
Street Address

_____
City State Zip Code

_____
Home Phone Number Mobile Phone Number

Relationship to you: _____

**My next choice:**

(not required)

✓ We will only ask this person if your first choice is not able to do it, or we are unable to contact them.

_____
First Name Last Name

_____
Street Address

_____
City State Zip Code

_____
Home Phone Number Mobile Phone Number

Relationship to you: _____

## Sign this document

In the order listed, I want the people above to make decisions for me if I am not able to myself. I understand that if I chose my spouse, and we later legally separate or get divorced, that my spouse will automatically lose the right to make decisions for me.

_____
Your signature Date Time

**Witness Signatures & Notary box on back** →

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**Either have two witnesses sign this <u>OR</u> have it notarized** (see below)

**Witness #1:** I am a competent adult. I am not one of the people listed above. I am not the patient's healthcare provider. I witnessed the patient sign this form.

Signature of Witness #1 Date Time

**Witness #2:** I am a competent adult. I am not one of the people listed above, nor am I the patient's healthcare provider. I am not related to the patient, and I am not entitled to get anything from the patient's estate. I witnessed the patient sign this form.

Signature of Witness #2 Date Time

**For Notaries to Fill Out**

**Do not notarize if witnesses have signed above**

State of Arkansas, County of _____

I am Notary Public in and for the State and County named above. The person who signed this form is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is signed above. This person personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

Date Commission Expires

Signature of Notary Public Date Time

(Place MR Label Here)
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Patient's Date of Birth:

**Print your name here**: _____

**Your birth date**: _____

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# My Living Will

**What this form does:** If you cannot make decisions yourself, this form tells your doctors and caregivers what you want so that they do not have to guess. **This form applies only if your health problems are so bad that you cannot make decisions for yourself.**

**What is life-support treatment?** Life-support treatment means medical care that keeps you alive when some part of your body fails. Some of the most common life-support treatments are

- **CPR** (to try to restart your heart and lungs when they have stopped working)
- **Breathing machines** (to help keep you breathing if you cannot on your own)
- **Dialysis** (to clean your blood if your kidneys stop working)
- **Artificial nutrition** (to feed you through tubes if you cannot swallow)

Step 1

## What care do you want if you become so sick that you are likely to die soon?

If my doctors decide I am likely to die soon and life-support treatment would only delay my death, then I want the following: (check **only one** of the boxes)

- ☐ I want my doctors to do everything medically reasonable to keep me alive.
- ☐ I **do not** want life-support treatment. If it has been started, I want it stopped so I die a natural death.
- ☐ I want my doctors and the person I have chosen as my healthcare agent to discuss and decide what is best for me on every issue.
- ☐ I have the following specific wishes: _____

_____

_____

✓Your **healthcare agent** is the person you listed in the Durable Power of Attorney for Healthcare.

Step 2

## What care do you want if you are not expected to recover from severe brain injury?

If my doctors do not expect me to recover enough to be aware of and interact with the world around me, I want the following:
(check **only one** of the boxes)

- ☐ I want my doctors to do everything medically reasonable to keep me alive.
- ☐ I **do not** want life-support treatment. If it has been started, I want it stopped so I die a natural death.
- ☐ I want my doctors and the person I have chosen as my healthcare agent to discuss and decide what is best for me on every issue.
- ☐ I have the following specific wishes: _____

_____

_____

✓**Severe brain injury** includes things like

- being in a coma or in a vegetative state that you will not come out of
- or having end-stage dementia

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**Step 3**

**If there is anything else you would like to tell your doctors, caregivers, or family, write it on these blank lines**

_____
_____
_____
_____
_____
_____

## Sign this document

I want my doctors, my healthcare agent, and any other caregiver to follow my wishes stated in this form. I intend for this to be a living will under the Arkansas Healthcare Decisions Act. I understand that I can change my mind at any time by creating a new living will or by telling my doctors, my healthcare agent, or my caregivers that my wishes have changed.

_____

Your Signature Date Time

**Step 4**

**Either have two witnesses sign this <u>OR</u>**
**have it notarized** (have the notary fill out the bottom of this page.)

**Witness #1:** I am a competent adult. I am not the patient's healthcare agent, or the patient's healthcare provider. I witnessed the patient sign this form.

_____

Signature of Witness #1 Date Time

**Witness #2:** I am a competent adult. I am not the patient's healthcare agent. I am not related to the patient, and I am not entitled to anything from the patient's estate. I am not the patient's healthcare provider. I witnessed the patient sign this form.

_____

Signature of Witness #2 Date Time

**For Notaries to Fill Out**

**Do not notarize if witnesses have signed this form**

State of Arkansas, County of _____

I am Notary Public in and for the State and County named above. The person who signed this form is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is signed above. This person personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

_____

Date my commission expires

_____

Signature of Notary Public Date Time