Your Right to Make Healthcare Decisions

Accepting Medical Treatment
Refusing Medical Treatment
Living Wills
Resuscitation Directives
Substitute Decision Makers
Medical Guardians

Includes these forms:

Medical Power of Attorney
Living Will
CPR Directive

c|h|a
Colorado Hospital Association

Revised January 2011

***YOUR RIGHT TO MAKE HEALTH CARE DECISIONS* is provided through the Colorado Hospital Association as a public service to the community.**

This booklet informs you about your right to make healthcare decisions, including the right to accept or refuse medical treatment.

It provides you with ready-to-use forms on which to record your decisions about medical treatment and your choice of the person you want to make decisions for you when you cannot.

These forms, and any written instructions you make ahead of time about your medical treatment, are called *advance directives*. This booklet explains the following advance directives and related subjects:

- Substitute Decision Makers: Medical Durable Power of Attorney, Proxy Decision Maker, Guardians
- Living Will
- Cardio-pulmonary Resuscitation (CPR Directive)
- Medical Orders for Scope of Treatment

FEDERAL LAW REQUIRES THAT YOU MUST BE GIVEN information on advance directives at the time you are admitted by any hospital, nursing home, HMO, hospice, home health care, or personal care program that receives federal funds (Medicare). You must also be given written information on policies of that facility or provider concerning advance directives.

If your advance directive conflicts with the facility's policy or a particular healthcare professional's moral or religious views, the facility or professional must transfer you to the care of another which will honor your advance directives.

You are not required to have advance directives in order to receive care and treatment, or for admission to a facility. You must only be informed about them. Whether or not you have advance directives, you will receive the medical care and treatment you need.

The advance directive forms in this booklet are specific to Colorado. If you spend a lot of time in another state, you should find out if your Colorado advance directives will be honored there. You may need to complete a separate set of advance directives according to the laws of that other state.

If you have advance directives from another state, they may still be valid in Colorado. However, it is recommended that you prepare new advance directives under Colorado law.

Preparing and signing (or *executing*) an advance directive does not take away your right to decide what you want, if you are able to do so, or to provide input to decisions about your care at any time. You may change your mind at any time about anything you have written in an advance directive.

It's very important to review your advance directives every few years, to make sure your choices are still valid and that other information, such as contact information, is up to date.

Keep your advance directives in a place that is easy to get to—not in a safe deposit box. Give copies of your directives to family members and friends who may be involved in your medical care.

Take copies of your advance directives with you when you are checking in to a healthcare facility for any outpatient or inpatient procedure. Make sure your primary physician and any healthcare professional providing treatment have copies of your directives and know your wishes.

If you complete a CPR directive (see page 13), be sure it is kept in a visible and handy place in your home so that it can be given quickly to any emergency medical personnel.

By providing *Your Right to Make Health Care Decisions* the Colorado Hospital Association assumes no legal liability for the enforceability or validity of the documents in any individual situation. We regret we are unable to provide advice to you about how to complete the forms. Your healthcare providers or an attorney can give you specific guidance.

FEDERAL AND COLORADO STATE LAW both say that *competent* adults (those able to make and express decisions) have the right to:

- Receive information in a way they can understand about the risks; benefits, alternatives, and likely outcomes of any recommended medical treatment;
- Give consent to medical treatment;
- Refuse medical treatment at any time for any reason, even if refusing treatment might result in death;
- Make known their wishes regarding medical treatment in advance of needing the treatment;

- Appoint a person to make medical treatment decisions for them when they cannot.

This booklet explains these rights and provides you with the forms you need under Colorado law to document your choices for medical treatment, including life support, and to appoint substitute decision makers.

These are important personal healthcare decisions, and they deserve careful thought. It's a good idea to talk about them with your doctor or other healthcare providers, family, friends, and other advisors, such as spiritual, financial, or legal. However, you are not required to consult a lawyer to complete any of these forms, and only the CPR directive requires a physician's signature.

YOUR RIGHT TO INFORMED CONSENT Except in emergencies, you must give consent to receive medical treatment. Before giving your consent, you must be must be told what the treatment is for, why and in what way it will be helpful, whether it has any risks or likely side effects, what results are expected or possible, and whether there are any alternatives.

If you have questions, you should ask them and make sure you understand the answers. Then you should think about the information and consider it carefully. If you can and want to, get a second opinion from another healthcare provider. Talk it over with family or friends—and then make your choice and tell your decision to your healthcare provider.

YOUR RIGHT TO ACCEPT MEDICAL TREATMENT Once you have been fully informed about a proposed treatment, you have the right to accept. Sometimes a verbal "OK" is enough, or you may be asked to sign a consent form. This form can be complicated and detailed. If you are not sure what it all means, ask for an explanation and be sure you understand before you sign.

YOUR RIGHT TO REFUSE MEDICAL TREATMENT Once you have been fully informed about a proposed treatment, you have the right to refuse. You can refuse any medical treatment at any time for any reason, even if you might get sicker or even die as a result.

YOUR RIGHT TO MAKE YOUR WISHES KNOWN If you have preferences about what medical treatments you want to accept or refuse, you have the right to make those wishes known. And you have the right to expect that your wishes will be honored, even if you get so sick you can't communicate or make decisions. In order to make sure your wishes are

respected, however, it is very important to discuss them with your family, your healthcare providers, other advisors or friends, and to write down your choices.

The written statements and documents you make to communicate your medical treatment decisions are called *advance directives*. In Colorado, there are three main types of advance directive: the Medical Durable Power of Attorney, the Living Will, and the CPR Directive. This booklet offers information and ready-to-use forms for all three. Other advance directive forms from other sources may be valid, too, if they follow Colorado law.

This booklet also briefly discusses the Medical Orders for Scope of Treatment (MOST). MOST is a summary of advance directives which, when signed by a healthcare professional, becomes a medical order set.

YOUR RIGHT TO APPOINT A SUBSTITUTE DECISION MAKER It can be very difficult to think ahead and imagine all the circumstances you might be in or the many healthcare decisions you might have to make. When people are very ill or badly injured, they are often unable to make or express their own decisions—they are *incapacitated*. Still, except in emergencies healthcare providers can't just go ahead with treatment without consent from the patient. If the patient can't give consent, someone else has to—but not just anybody else.

In some states, the law authorizes particular people in a particular order to act as *substitute* decision makers for an incapacitated patient: spouse first, adult children next, then parents, grandparents, siblings, etc. Colorado law does not have such a prioritized list of substitute decision makers. Instead, individuals, before they are incapacitated, should appoint a substitute decision maker, or *healthcare agent*.

MEDICAL DURABLE POWER OF ATTORNEY You appoint your healthcare agent by completing a *Medical Durable Power of Attorney* (*MDPOA*) form. An MDPOA form, along with more information about the MDPOA/healthcare agent, is provided in this booklet. A healthcare agent only has authority to make healthcare decisions. An MDPOA cannot pay your bills, buy or sell real estate or other items of property for you, manage your bank accounts, etc. For that, you need to appoint a Financial or General Durable Power of Attorney. Forms to appoint other powers of attorney are available free from various Web sites or office supply stores, but it is a good idea to consult an attorney first. Low-cost legal advice is available from the Colorado Bar Association, www.cobar.org, or 303.860.1115.

If you do not appoint a healthcare agent or MDPOA while you are able to make your own decisions, Colorado law offers two options: selection of a Proxy Decision Maker for Healthcare or appointment of a guardian.

PROXY DECISION MAKER FOR HEALTHCARE When a doctor has determined that you cannot make your own decisions, and if you have not appointed a healthcare agent, the doctor must gather together as many *interested persons* as possible. These are people who know you well and have a close interest in your well-being, including your spouse or partner, parents, children, grandparents, siblings, even close friends. Then the assembled group must choose one person to be your Proxy Decision Maker. Ideally, this person knows you and your wishes for treatment best. If your wishes are not known, the Proxy must act in your best interests.

The doctor must make a reasonable effort to tell you who the Proxy is, and you have a right to object to the person selected to be Proxy or to any of the Proxy's decisions. If you later regain the ability to make and express your own decisions, the Proxy is relieved of duty.

Anyone with a close interest in your care can be included in the group that selects the Proxy; no one can be deliberately excluded. However the membership of the group depends on whom the doctor knows to contact and whether they are available. This process is somewhat unusual in the healthcare field. If some Colorado healthcare providers do not know about it, they may just turn to whomever among your family and friends happens to be there at the time. This might work for the time being, but if there is any kind of conflict, a decision maker chosen in this way has no real legal standing.

Once the group of interested persons reaches agreement, the doctor then records the selection of the Proxy Decision Maker in your medical record. The Proxy has almost the same powers of decision making that you would have. The Proxy may consult with your healthcare providers, review your medical records, and make any and all decisions regarding your healthcare except one: A Proxy Decision Maker cannot decide to withhold or withdraw artificial nourishment (water and nutrients delivered by tube) unless two physicians, one of whom is trained in neurology, agree that artificial nourishment would only prolong the moment of your death. Also, the Proxy's authority tends to be limited to the timeframe of a particular medical crisis; it is not *durable* past the immediate need for healthcare decisions.

The Proxy must make an effort to consult with you about the decisions to be made and also must consult with the rest of the group. If the group cannot

pick a Proxy to begin with, or if at any time the group cannot agree about particular decisions, the only option is for someone in the group to go to court to ask for appointment of a guardian.

GUARDIANS Guardians are appointed by the court to perform a certain set of duties on behalf of an incapacitated person. This person is called a *ward* or *protected person.* The law regards a person as being *incapacitated* when he or she is unable to make or communicate decisions concerning himself or herself. This may be due to mental illness, mental impairment, physical illness or disability, chronic use of drugs and/or alcohol, or other causes.

A court order might appoint a guardian to make medical care and treatment decisions or to manage the ward's financial affairs. A court might appoint a limited guardian to provide particular services for a specific length of time. Generally the duties of a guardian are to decide where the ward should live; to arrange for necessary care, treatment, or other services for the ward; and to see that the basic daily personal needs of the ward are met, including food, clothing and shelter.

Any person aged 21 or over, or an appropriate agency, may be appointed as a guardian. Frequently, guardians are members of the ward's family or close friends of the ward, but professional senior care managers and some county departments of Adult Protective Services may also serve as guardians.

Guardianship can be shared by more than one individual; for instance, one person handling medical decisions and another financial. A guardian is not required to provide for a ward out of his or her own money, nor is he or she required to live with the ward. In addition, a guardian is not responsible for a ward's behavior. It is important to know that, except in emergency situations, the court process to appoint a guardian may take several months.

THE MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST) form is a 1-page, 2-sided document that summarizes in check-box style choices for key life-sustaining treatments including CPR, general scope of treatment, antibiotics, and artificial nutrition and hydration. For each type of treatment, the patient may refuse treatment, request full treatment, or specify limitations.

The MOST is primarily intended for use by chronically or seriously ill persons in frequent contact with healthcare providers, or already living in a nursing facility. It is completed by the patient or authorized decision maker along

with a healthcare provider who can explain what each of the choices means for that patient at that time. Then it is signed by the patient or healthcare agent/Proxy and a physician, advanced practice nurse, or physician's assistant. When signed, it becomes a medical order set, not an advance directive.

The MOST stays with the patient and is honored in any setting: hospital, clinic, day surgery, long-term care facility, assisted living residence, hospice, or at home. In this way, the MOST closes gaps in communication about treatment choices as patients transfer from setting to setting. The original is brightly colored for easy identification, but photocopies, faxes, and electronic scans are also valid.

The MOST does not replace or revoke advance directives. Choices on the MOST should be consistent with any advance directives the patient previously completed, but the MOST does not cover every treatment or instruction that might be addressed in an MDPOA or Living Will. The choices and directives documented there are still valid. The MOST overrules prior instructions only when there is a direct conflict. A section on the back prompts patients and providers to regularly review, confirm, or update choices based on changing conditions.

A MOST form is not included in this booklet; if you would like more information about the MOST form or program, please consult a healthcare provider or visit www.ColoradoAdvanceDirectives.com.

ORGAN AND TISSUE DONATION Any advance directive may include a written statement of your desire to donate organs or tissues. Please be aware that if you do wish to donate organs, your advance directive may be set aside for a time to allow your organs to be recovered before life-sustaining treatment is withdrawn (see section on the Living Will, page 11). If you refuse CPR, or cardio-pulmonary resuscitation, by executing a CPR directive (see page 13), you may not be able to donate organs, but you can still donate tissues, subject to some limitations of age, health status, and sexual orientation. For more information about organ and tissue donation, consult with your healthcare provider or contact Donor Alliance, www.DonorAlliance.org, or (303) 329-4747. If you do wish to donate organs or tissues, be sure your family knows of your decision, as they will be asked to give consent to the donation procedure—and they have the final say.

Medical Durable Power of Attorney

A **MEDICAL DURABLE POWER OF ATTORNEY (MDPOA)** is a document you sign naming someone to make your healthcare decisions if and when you are not able to. The person you name is called your *healthcare agent*. Your MDPOA can become effective immediately, or you can make it become effective only when you are unable to make your own medical decisions.

You can appoint anyone to be your healthcare agent as long as that person is at least 18 years old, mentally competent, and willing to be your agent. Your agent should also be someone who can confidently deal with lots of healthcare providers over what could be a long time. It is preferable to pick an agent who lives in the same state or even city as you do, and it's also a good idea to appoint one or two back-up agents, in case your first choice is not available or able to serve. Appointing two or more people as co-agents is not recommended.

Your healthcare agent has all the powers of decision making you do: He or she can consult with healthcare providers, review or get copies of your medical records, and make all necessary healthcare treatment and placement decisions. The agent must act according to his or her understanding of what your wishes and preferences would be. He or she must set aside his or her own values and preferences and do what you would do.

Therefore, it is very important to be sure your agent understands what your wishes are, what you consider to be acceptable, and when you would say no. Talk to your agent about your values, any religious or moral commitments you have, and your goals for treatment. What burdens of treatment (side effects, pain, nausea, fatigue, limitations on activity or thinking, etc.) are

*(**Medical Durable Power of Attorney** continued)*

acceptable to you and which are not? What benefits do you hope the treatment will provide?

Do not assume that the person you pick to be your agent knows all of this, just because he or she knows you well. Studies have shown that even spouses who have been married for decades are often wrong when asked to guess what their partners would prefer! In fact, your spouse or life partner may not be the best choice of agent, just because of his or her close involvement in the outcome of your treatment. If you appoint your spouse as your agent, and then later you are divorced, legally separated, or your marriage is annulled, your former spouse is automatically removed as your agent unless expressly stated otherwise in your MDPOA.

You may put instructions into your MDPOA document to help guide your agent and your healthcare providers. A MDPOA form appears at the back of this booklet .

Your MDPOA does not need to be witnessed or notarized. However, most other states require witnesses, so if you plan to use your MDPOA in another state, it's a good idea to have it witnessed. You can cancel, or *revoke*, your MDPOA at any time, assuming you have the mental capacity to do so, and your agent can resign at any time. If you have not appointed a back-up agent and can't make decisions for yourself, then a Proxy Decision Maker must be selected or a guardian appointed by the court.

Living Will

A **LIVING WILL** is a document you sign telling your doctors to stop or not start life-sustaining treatments if you are in a terminal condition and can't make your own decisions or if you are in a *persistent vegetative state* (PVS). A terminal condition is one that is incurable or irreversible and for which life-sustaining treatment will only postpone the moment of death. Persistent vegetative state results from a severe brain injury and generally means that the person is alive and may appear to sleep and wake, but is completely unaware of his or her surroundings; cannot speak, drink, or eat; and may not be able to feel or react to pain.

A Living Will only goes into effect 48 hours after two doctors certify that you are in a terminal condition and can't make your own decisions or you are in PVS. Your doctors must make a good effort to notify persons close to you that this certification has been made and that they will withdraw or withhold life-sustaining treatment within two days. You can include a list of persons to be notified in the Living Will document, with their contact information. You can also include a list of persons authorized to talk to your doctors about your condition and care. These persons are not authorized to make any decisions about your care, however.

In Colorado, you may also designate in your Living Will that your doctors should stop or not start any tube feeding and other forms of artificial nutrition and hydration, once the terminal or PVS certification has been made, unless they consider it is necessary to provide comfort or relieve pain. You may also include other instructions about your care, but these instructions will only go into effect at the same time as the Living Will: when your doctors certify you are in a terminal condition and can't make your own decisions or you are in PVS. The Living Will is not the place to record general

*(**Living Will** continued)*

medical directives about your care in any condition that is not terminal or PVS. It is also not the place to record instructions about property or personal items.

Two competent adult witnesses must sign your Living Will. However, the witnesses cannot be your doctor or any employee of your doctor, any employee of the facility or agency providing your care, your creditors, or people who may inherit your money or property. Other patients or residents in the facility where you are receiving care can witness your Living Will as long as they are competent to do so.

Your doctors, Proxy Decision Maker, or guardian cannot override your Living Will. In the Living Will document or in the MDPOA document, you can give your healthcare agent the authority to override all or part of your Living Will. If you do not give your agent this authority, your Living Will cannot be revoked or overridden by your agent.

You can cancel or change your Living Will at any time. You can do this by destroying it, by signing a statement that you no longer want it, or you may prepare a new one. If you cancel or change your Living Will, you should tell your family, your doctor, and anyone who has a copy of it that it has been canceled or changed.

A Living Will form appears at the back of this booklet. This form is consistent with Colorado law. You don't have to consult a doctor or lawyer to complete a Living Will, although you might wish to seek medical or legal advice.

CPR Directive

A **CPR (CARDIO-PULMONARY RESUSCITATION) DIRECTIVE** allows you—or your agent, guardian, or Proxy Decision Maker on your behalf—to refuse resuscitation. CPR is an attempt to revive someone whose heart and/or breathing has stopped by using special drugs and/or machines or by firmly and repeatedly pressing the chest. If you don't have a CPR Directive and your heart and/or lungs stop or malfunction, your consent to CPR is assumed. However, if you have a CPR Directive refusing resuscitation, and your heart and/or lungs stop or malfunction, then paramedics and doctors, emergency personnel or others will not press on your chest or use breathing tubes, electric shock, or other procedures to get your heart and/or lungs working again.

A CPR Directive is not exactly the same as a DNR (Do Not Resuscitate) order, although many people refer to the CPR Directive as a DNR. A DNR order is an order written in your medical chart by your doctor while you are being cared for in a healthcare facility, such as a hospital or nursing home. The doctor will likely discuss this order with you or your surrogate decision maker, but does not have to. DNR orders are written when your doctor believes that resuscitation would not work or might cause more harm than good. (Fewer than 1 in 10 very elderly, frail, or seriously ill persons will survive a resuscitation attempt; if they do survive, they might end up with traumatic injuries or brain damage.) If you recover well enough to leave the facility, the DNR order expires at your discharge.

A CPR Directive is a type of advance directive that you make for yourself or an authorized decision maker makes for you, and it is valid outside of the healthcare facility. Signing a CPR Directive does not mean you won't receive other medical care such as medicine, other treatment for pain, bleeding, broken bones or comfort care.

(continued)

*(**CPR Directive** continued)*

Anyone over the age of 18 can sign a CPR Directive. According to the CPR Directive law, a physician must also sign the CPR directive, indicating that you have been informed of what will happen if you refuse CPR and that refusal is appropriate due to your age or medical condition. You can revoke a CPR directive at any time by destroying it or by writing a statement that you revoke it on the form. If you sign a CPR directive for yourself, no one else can revoke it. If your agent, Proxy, or guardian signs one for you, they can revoke it.

Even if you have other types of advance directives, a CPR Directive is strongly recommended if you do not want to be resuscitated. Colorado law does not require that a specific CPR Directive form be used and copies, faxes, and scans of the form are also valid. A template prepared and approved by the Colorado Department of Public Health and Environment appears on the reverse side of this fold.

If you do sign a CPR directive, you should keep the form handy and visible so that emergency personnel or anyone else trying to help you in an emergency can see the form and understand your wishes. At home, place the CPR directive in a clearly marked envelope on your refrigerator, by your bedside, or by your front door. If you are out and about, carry one in your purse or wallet. A CPR alert bracelet or necklace can be ordered from Award and Sign Connection, www.AwardAndSign.com, 303-799-8979, or MedicAlert Foundation, www.MedicAlert.org, 888-633-4298.

CPR DIRECTIVES AND MINORS After a physician issues a Do Not Resuscitate order for a minor child—and only then—the parents of the minor, if married and living together, or the custodial parent or the legal guardian may execute a CPR Directive for the child.

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This pamphlet was originally developed by the Advance Directives Coalition. This revision was prepared by the Colorado Advance Directives Consortium in collaboration with the Colorado Hospital Association.

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For more information or downloadable versions of the forms included in this booklet visit www.ColoradoAdvanceDirectives.com

For help or more information about completing the forms, contact your local physician, hospital, senior group, attorney, or any of the organizations below:

Colorado Advance Directives Consortium
Colorado Bar Association
Colorado Department of Public Health and Environment
Colorado Department of Social Services
Colorado Hospital Association
Colorado Medical Society
Legal Aid Society
The Legal Center for Persons With Disabilities
…or a licensed healthcare facility.

Single copies of this booklet are available at no cost from the Colorado Hospital Association, 720-489-1630

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Medical Durable Power of Attorney for Healthcare Decisions

I. Appointment of Agent and Alternates

I, _____ ,
Declarant, hereby appoint:

_____
Name of Agent

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative telephone number

_____
Agent's home address

as my Agent to make and communicate my healthcare decisions when I cannot. This gives my Agent the power to consent to, or refuse, or stop any healthcare, treatment, service, or diagnostic procedure. My Agent also has the authority to talk with healthcare personnel, get information, and sign forms as necessary to carry out those decisions.

If the person named above is not available or is unable to continue as my Agent, then I appoint the following person(s) to serve in the order listed below.

_____
Name of Alternate Agent #1

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative telephone number

_____
Agent's home address

_____
Name of Alternate Agent #2

_____
Agent's Best Contact Telephone Number

_____
Agent's email or alternative telephone number

_____
Agent's home address

II. When Agent's Powers Begin

By this document, I intend to create a Medical Durable Power of Attorney which shall take effect either (initial one):

_____ (*Initials*) Immediately upon my signature.

_____ (*Initials*) When my physician or other qualified medical professional has determined that I am unable to make my or express my own decisions, and for as long as I am unable to make or express my own decisions.

III. Instructions to Agent

My Agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way. If I have not expressed a choice about the decision or healthcare in question, my Agent shall base his or her decisions on what he or she, in consultation with my healthcare providers, determines is in my best interest. I also request that my Agent, to the extent possible, consult me on the decisions and make every effort to enable my understanding and find out my preferences.

State here any desires concerning life-sustaining procedures, treatment, general care and services, including any special provisions or limitations:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

My signature below indicates that I understand the purpose and effect of this document:

_____
Signature of Declarant *Date*

Pursuant to Colorado Revised Statute 15–14.503–509

Addendum to Medical Durable Power of Attorney — *recommended, not required*

1. Signature of the Appointed Agent

Although not required by Colorado law, my signature below indicates that I have been informed of my appointment as a Healthcare Agent under Medical Durable Power of Attorney for (name of Declarant)

_____ .

I am at least eighteen (18) years old. I accept the responsibilities of that appointment, and I have discussed with the Declarant his or her wishes and preferences for medical care in the event that he or she cannot speak for him- or herself.

I understand that I am always to act in accordance with his or her wishes, not my own, and that I have full authority to speak with his or her healthcare providers, examine healthcare records, and sign documents in order to carry out those wishes. I also understand that my authority as a Healthcare Agent is only in effect when the Declarant is unable to make his or her own decisions and that it automatically expires at his or her death.

If I am an alternate Agent, I understand that my responsibilities and powers will only take effect if the primary Agent is unable or unwilling to serve.

_____

Primary Agent's Signature

_____

Printed Name

_____

Date

_____

Alternate Agent #1 Signature

_____

Printed Name

_____

Date

_____

Alternate Agent #2 Signature

_____

Printed Name

_____

Date

2. Signature of Witnesses and Notary

The signature of two witnesses and a notary are not required by Colorado law for proper execution of a Medical Durable Power of Attorney; however, they may make the document more acceptable in other states.

This document was signed by (*name of Declarant*)

_____

in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We are at least eighteen (18) years old.

_____

Signature of Witness

_____

Printed Name

_____

Address

_____

_____

Signature of Witness

_____

Printed Name

_____

Address

_____

Notary (optional)

State of _____

County of _____

SUBSCRIBED and sworn to before me by

_____ , the Declarant,

and _____

and _____

witnesses, as the voluntary act and deed of the Declarant this day of _____, 20____.

_____

Notary Public

My commission expires: _____

Pursuant to Colorado Revised Statute 15–14.503–509

Advance Directive for Surgical / Medical Treatment (Living Will)

On completion, give copies to your physician, family members, and Healthcare Agent.
If you wish to revoke or replace this document, mark it clearly as "Revoked" or destroy it and all its copies, if possible.
If you do not understand the choices and options, seek advice from a healthcare provider or other qualified advisor.

I. DECLARATION

I, _____ , am at least eighteen (18) years old and able to make and communicate my own decisions. It is my direction that the following instructions be followed if I am diagnosed by two qualified doctors to be in a terminal condition or Persistent Vegetative State.

A. Terminal Condition If at any time my physician and one other qualified physician certify in writing that I have a terminal condition, and I am unable to make or communicate my own decisions about medical treatment, then:

1. Life-Sustaining Procedures (*initial one*)

_____ (*Initials*) I direct that all life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____ (*Initials*) I direct that life-sustaining procedures shall be continued for/until (state timeframe or goal):

_____

2. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

_____ (*Initials*) Artificial nutrition and hydration shall not be continued.

_____ (*Initials*) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

_____

_____ (Initials) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

B. Persistent Vegetative State If at any time my physician and one other qualified physician certify in writing that I am in a Persistent Vegetative State, then:

1. Life-Sustaining Procedures (*initial one*)

_____ (*Initials*) I direct that life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____ (*Initials*) I direct that life-sustaining procedures shall be continued for/until (state timeframe or goal):

_____

2. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

_____ (*Initials*) Artificial nutrition and hydration shall not be continued.

_____ (*Initials*) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

_____

_____ (*Initials*) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

II. OTHER DIRECTIONS

Please indicate below if you have attached to this form any other instructions for your care after you are certified in a terminal condition or Persistent Vegetative State (for instance, to be enrolled in a hospice program, remain at or be transferred to home, discontinue or refuse other treatments such as dialysis, transfusions, antibiotics, diagnostic tests, etc.) *(initial one)*:

_____ (*Initials*) Yes, I have attached other directions.

_____ (*Initials*) No, I do not have any other directions.

III. RESOLUTION WITH MEDICAL POWER OF ATTORNEY (*initial one*)

_____ (*Initials*) My Agent under my Medical Durable Power of Attorney shall have the authority to override any of the directions stated here, whether I signed this declaration before or after I appointed that Agent.

_____ (*Initials*) My directions as stated here may not be overridden or revoked by my Agent under Medical Durable Power of Attorney, whether I signed this declaration before or after I appointed that Agent.

Advance Directive for Surgical / Medical Treatment (Living Will) (continued)

IV. CONSULTATION WITH OTHER PERSONS

I authorize my healthcare providers to discuss my condition and care with the following persons, understanding that these persons are not empowered to make any decisions regarding my care, unless I have appointed them as my Healthcare Agents under Medical Durable Power of Attorney.

Name *Relationship*

_____

_____

_____

_____

_____

V. NOTIFICATION OF OTHER PERSONS

Before withholding or withdrawing life-sustaining procedures, my healthcare providers shall make a reasonable effort to notify the following persons that I am in a terminal condition or Persistent Vegetative State. My healthcare providers have my permission to discuss my condition with these persons. I do NOT authorize these persons to make medical decisions on my behalf, unless I have appointed one or more of them as my Agent(s) under Medical Durable Power of Attorney.

Name *Telephone number or email*

_____

_____

_____

_____

_____

VI. ANATOMICAL GIFTS

_____ (*Initials*) I wish to donate my (check one or both)
☐ organs and/or ☐ tissues, if medically possible.

_____ (*Initials*) I do not wish donate my organs or tissues.

VII. SIGNATURE

I execute this declaration, as my free and voluntary act, this day of _____, 20____.

_____

Declarant signature

VIII. DECLARATION OF WITNESSES

This declaration was signed by (*name of Declarant*)

_____

in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We did not sign the Declarant's signature. We are not doctors or employees of the attending doctor or healthcare facility in which the Declarant is a patient. We are neither creditors nor heirs of the Declarant and have no claim against any portion of the Declarant's estate at the time this declaration was signed. We are at least eighteen (18) years old and under no pressure, undue influence, or otherwise disqualifying disability.

_____

Signature of Witness

_____

Printed Name

_____

Address

_____

_____

Signature of Witness

_____

Printed Name

_____

Address

_____

Notary (optional)

State of _____
County of _____
SUBSCRIBED and sworn to before me by
_____ , the Declarant,
and _____
and _____
witnesses, as the voluntary act and deed of the Declarant this day of _____, 20____.

_____

Notary Public
My commission expires: _____

Patient's or Authorized Agent's Directive to Withhold Cardio-Pulmonary Resuscitation (CPR)

This template is consistent with rules adopted by the Colorado State Board of Health at 6 CCR 1015-2

Patient's Information

Patient's Name _____
(Printed Name)

If Applicable Name of Agent/Legally Authorized Guardian/Parent of Minor Child _____
(Printed Name)

Date of Birth ____ /____ /_____ Gender ☐ Male ☐ Female ☐ Eye Color _____ ☐ Hair Color _____

Race Ethnicity ☐ Asian or Pacific Islander ☐ Black, non-Hispanic ☐ White, non-Hispanic
☐ American Indian or Alaska Native ☐ Hispanic ☐ Other

If Applicable- Name of hospice program/provider _____

Physician's Information

Physician's Name _____
(Printed Name)

Physician's Address _____

Physician's telephone ( ) _____ Physician's Colorado License # _____

Directive Attestation

Check **ONLY** the information that applies:

☐ Patient I am over the age of 18 years, of sound mind and acting voluntarily. It is my desire to initiate this directive on my behalf. I have been advised that as a result of this directive, if my heart or breathing stops or malfunctions, I will not receive CPR and I may die.

☐ Authorized Agent/Legally Authorized Guardian/Parent of Minor Child I am over the age of 18 years, of sound mind, and I am legally authorized to act on behalf of the patient named above in the issuance of this directive. I have been advised that as a result of this directive, if the patient's heart or breathing stops or malfunctions, the patient will not receive CPR and may die.

☐ Tissue Donation I hereby make an anatomical gift, to be effective upon my death of:
☐ Any needed tissues
The following tissues ☐ Skin ☐ Cornea ☐ Bone, related tissues and tendons

I hereby direct emergency medical services personnel, health care providers, and any other person to withhold cardio-pulmonary resuscitation in the event that my/the patient's heart or breathing stops or malfunctions. I understand that this directive does not constitute refusal of other medical interventions for my/the patient's care and comfort. If I/the patient am/is admitted to a healthcare facility, this directive shall be implemented as a physician's order, pending further physician's orders.

_____ _____
☐ Signature of Patient Physician Signature
☐ Authorized Agent/Legally Authorized Guardian/Parent of Minor Child

_____ _____
Date Date