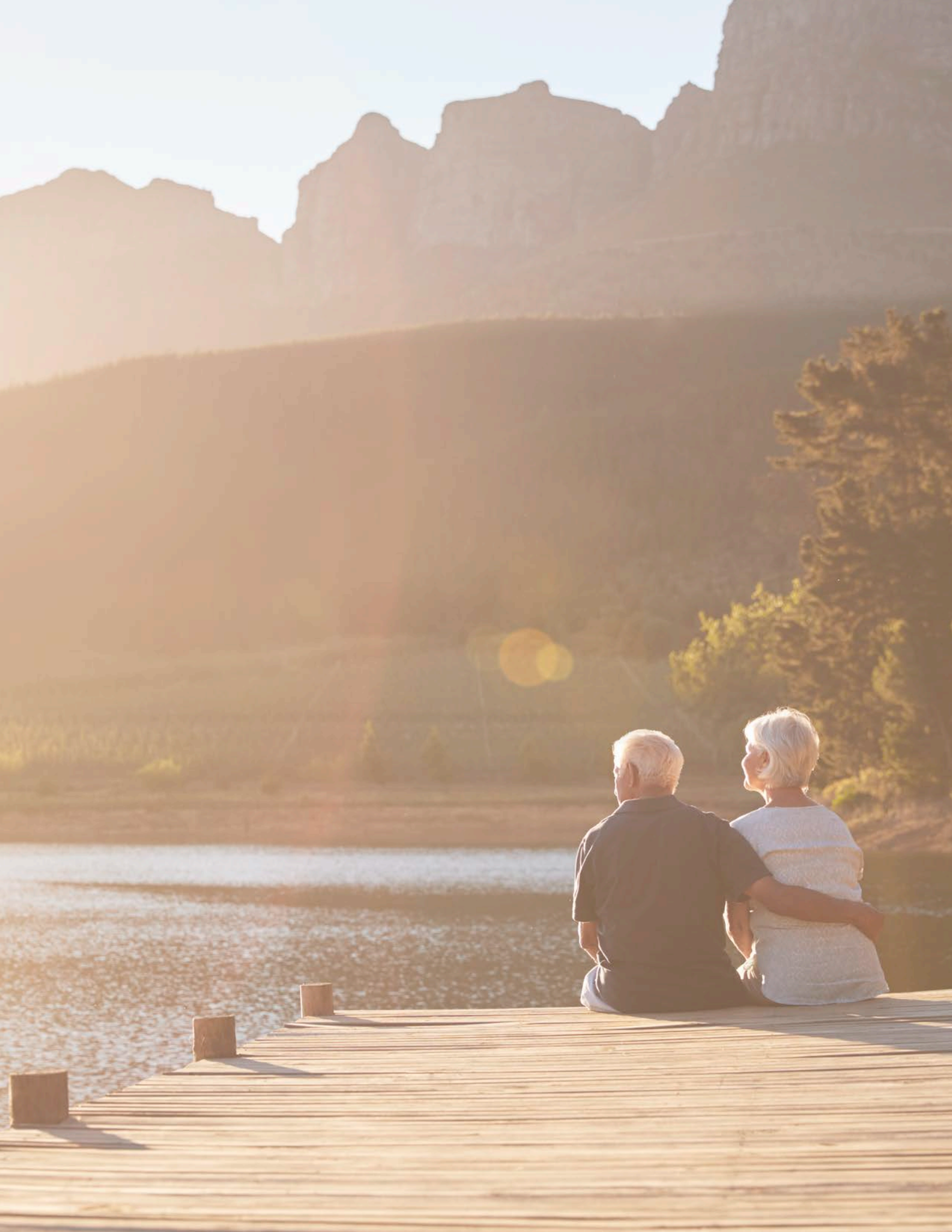
Advanced Care Management

A guidebook for patients experiencing serious or life-limiting illness.

Memorial HEALTH SYSTEM



We recommend taking this guidebook to healthcare appointments and hospitalizations.

PATIENT INFORMATION

Name _____ Date of birth _____

Address _____

Phone number _____

Current POA/Next of kin/Family members _____

Current caregiver (if applicable)_____

Spiritual/Cultural affiliation _____

Other pertinent documents and where to find them _____

_____

_____

Current medical problems or conditions _____

_____

_____

ADVANCE CARE PLAN SUMMARY

I completed this guidebook with _____

I have discussed my healthcare wishes with ☐ POA-HC ☐ Family ☐ Physician

☐ Others _____

My desired code status ☐ Full code ☐ DNR ☐ Undecided

My goals of care ☐ Full treatment ☐ Selective treatment ☐ Comfort-focused treatment

ADVANCE DIRECTIVES

☐ Power of Attorney ☐ Living Will ☐ POLST ☐ Other _____

Location of advance directives: _____

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INTRODUCTION

During our lifetimes, we plan for major transitions like going to college, getting married and retiring. But it's hard for most of us to think about the biggest transition of all: the end of our lives.

Like many people, you may have put off making decisions about healthcare treatment. But, when you have a serious or life-limiting illness, it becomes even more important to communicate your wishes and preferences before a decline or hospitalization. Advance care planning is about having those conversations and ensuing your wishes are met.

Carrie's Story

Carrie was **65 years old and had just retired.** She and her husband divorced about 15 years ago. Their twin boys were attending college when she was diagnosed with terminal lung cancer. Carrie had read about advance care planning, the importance of documenting her wishes and discussing them with family. She asked her doctor if it was time to take this step. When her doctor recommended hospice care, Carrie spent much time talking with her family about her wishes, what was important to her and what types of treatment she would accept. She completed her advance directive and filed the necessary paperwork with her healthcare provider. She did not want to burden her family with these decisions. When she grew too sick to direct her care, her twin boys knew exactly what their mother wanted, and honored her wishes.

Mary's Story

Mary was **85 years old. Her husband of 60 years passed away one year ago.** He had been her caregiver since she was diagnosed with Alzheimer's disease. Her health had declined since his death—she was forgetting to eat and take her medicine and her safety was at risk. But she still had good days where she was able to care for herself. She decided it was best that she go into a nursing home. There, the staff asked if she had a power of attorney for healthcare or an advance directive. Mary's parents had passed many years prior, as had her sisters, leaving her with no living family. The nursing home staff assisted Mary in completing her advance directive and encouraged her to name a Durable Power of Attorney for Healthcare. Luckily, Mary's long-time neighbor and friend felt comfortable assuming this responsibility. As the Alzheimer's progressed, Mary's friend was able to make decisions on her behalf. By documenting her wishes early, Mary avoided needing a court-appointed guardian.

Understanding My Serious Illness and My Wishes

We all have values, beliefs and goals that guide our thinking about life and death. Before you can educate your family and loved ones about your wishes, it is important to understand your own personal preferences. Take some time to reflect and ask yourself what is most important in your life.

Use the following questions and chart to help you think through your preferences and values about your health and the care you receive.

- What is your understanding of where you are in your illness?

_____

_____

- What have you and your doctor discussed about what to expect as your illness progresses?

_____

_____

- How has your illness interfered with your daily activities?

_____

_____

IT IS IMPORTANT THAT I AM ABLE TO:	Less Important	Very Important
Live as long as possible	5	
Focus on my quality of life, rather than living a long time	5	
Care for myself without assistance	5	
Get out of bed (not be bedridden)	5	
Move about independently	5	
Recognize family and friends	5	
Make my own decisions	5	
Live in my home	5	
Be free of chronic, severe pain	5	
Live without long-term life support like breathing machines, feeding tubes or dialysis	5	
Be financially independent	5	
Leave a substantial estate to people or causes important to me	5	
Live and die in keeping with my beliefs	5	
Die naturally (without the use of machines or attempts at resuscitation)	5	
Have spiritual peace	5	

- What are your most important goals if your condition were to worsen?

_____

_____

- What worries you the most about the future with your health?

_____

_____

- If your health were to worsen, what are you willing to give up for the possibility of gaining more time?

_____

_____

- What abilities are so crucial to you that you can't imagine living without them?

_____

_____

- What do you hope for most about the future with your health?

_____

_____

CARE DECISIONS

What do I need to know about care decisions to prepare my advance directive?

LEARN ABOUT LIFE-SUSTAINING TREATMENTS

Life-sustaining treatments keep a person alive when the body is not able to function on its own. Your wishes about life-sustaining treatment will likely depend on the situation.

In some cases, life-sustaining treatments may help to restore normal functions and improve your condition. However, there are situations in which you may not want to prolong your life with these treatments.

The most common end-of-life medical decisions involve:

Cardiopulmonary resuscitation (CPR)

Cardiopulmonary Resuscitation (CPR)	Do Not Resuscitate (DNR) Order	Artificial Nutrition and Hydration

One of the most common life-sustaining medical decisions involves cardiopulmonary resuscitation, also known as CPR.

CPR is used when the heart stops (cardiac arrest) or breathing stops (respiratory arrest). Treatment for cardiac arrest may include chest compressions, electrical shocks and medication to restore heart function. Respiratory arrest treatment may involve inserting a tube through your mouth or nose into the trachea (windpipe) to artificially support or restore your breathing function. This tube is connected to a mechanical ventilator.

Do Not Resuscitate (DNR) Order

A DNR order prevents your healthcare team from initiating CPR. A physician may write a DNR order at your request, or at the request of your family or appointed healthcare agent. The DNR order must be signed by a doctor to be valid.

A DNR order only covers CPR. When you request a DNR order, he or she may also ask if you want a “do not intubate” order. Intubation is the placement of a tube in the nose or mouth to help you breathe when you cannot breathe adequately yourself. Intubation might prevent a heart attack or respiratory arrest.

Although CPR will not be given to a person who has a DNR order, the care team will take other steps to keep you as comfortable as possible.

Artificial nutrition and hydration

Certain treatments allow a patient to receive nutrients and fluid even if they cannot eat or drink. When considering whether to allow artificial nutrition and hydration, consider:

1. What is the goal of artificial nutrition and hydration?
2. Will it prolong my life?
3. Will it make me more comfortable?
4. Are there religious, cultural or personal values that would affect my decision?

ADVANCE DIRECTIVES

An advance directive is a legal document that outlines your wishes for medical treatment if you are unable to make decisions and communicate your wishes for yourself. An advance directive allows you to think about what kind of medical treatment you would want and write down your wishes before a health crisis occurs.

Illinois law allows you to make four different advance directives: Power of Attorney for Healthcare, Living Will, Practitioner Order for Life Sustaining Treatment and Mental Health Treatment Declaration.

COMMONLY USED ADVANCE DIRECTIVES

Power of Attorney for Healthcare (POA-HC)

- This is a legal document that allows you to choose someone to make all healthcare-related decisions for you in the event you are unable to, or do not wish to, make decisions for yourself.
- The person you appoint is called your "primary agent." Your agent should be someone who knows you well—someone who knows what is most important to you and what your wishes would be for medical treatment. Your agent should be someone who feels comfortable carrying out your healthcare wishes for you.
  - You can name back-up agents, called "successor agents," who can act as your POA-HC if your primary agent is unable to do so.
  - Only one person can act as your healthcare agent at a time.
- The POA-HC document is valid from the time you sign it until your death, unless you specify a time limit or create a new POA-HC document.
- Your agent has the authority to make any and all healthcare decisions when you are unable to make decisions for yourself, unless you state specific instructions or limitations on your POA-HC document.

Living Will

- A Living Will is a document that informs your loved ones, POA-HC and healthcare providers that you do not want life-prolonging or death-delaying treatment if you are suffering from an incurable or irreversible condition and death is imminent
- It also allows you to outline your specific wishes regarding your medical care.
- This document serves as a piece of guidance to your loved ones and providers about your wishes for medical treatment at the end of your life, if you cannot communicate for yourself. It is not a medical order and is not as legally durable as a POA-HC document. If you are unable to speak for yourself, your POA-HC will be the appointed person to make decisions on your behalf about stopping life-prolonging treatment and starting comfort-focused treatment.

Practitioner Order for Life-Sustaining Treatment (POLST)

- This is a medical order that documents the types of treatments, especially life-sustaining treatments, a person would want at the end of life if they were seriously ill.
- It allows people who are elderly, frail and/or seriously ill to state whether or not they would want cardiopulmonary resuscitation if they went into cardiopulmonary arrest.
- Additionally, it allows a person to state their preferences for the level of treatment they would wish to receive if their medical condition were to decline.
- The form requires a doctor's signature in order to be valid. Once signed, it will be honored by all medical staff.
- It travels with the person to ensure that treatment preferences are honored across all settings of care: home, hospital, doctor's office or nursing facility.

STORING ADVANCE DIRECTIVES

It's important to keep your advance directive documents in a safe, easily accessible place. Make sure your loved ones know where to find them. Give photocopies of the documents to your medical power of attorney, and be sure your doctors and anyone else involved in your care have copies as well. This can include family members, close friends and clergy. Some hospitals also keep copies of patients' advance directives on file in case the need arises. When you are admitted to the hospital for a surgery or other care, bring a copy with you and ask that it be placed in your medical record.

APPROACHING MY FAMILY

It is important to have a conversation about your end-of-life wishes with your loved ones. This conversation can be difficult, but speaking with your loved ones about your wishes before a medical crisis occurs can give them a clear understanding of your wishes for end-of-life care. You should also talk about your spiritual and religious beliefs surrounding a meaningful life, death and dying.

The following questions can serve as a guide to discussing your end-of-life wishes with your family:

- Who would you want to include in this discussion? Is there anyone who would not feel comfortable discussing your wishes?

_____

_____

- Who would you want (or not want) to be involved in your care?

_____

_____

- Are there any relationships in your life that you feel need repaired?

_____

_____

- How important is it to be physically independent and stay in your own home?

_____

_____

- What impact would your illness have on your loved ones, including those who would be your caregivers?

_____

_____

- What matters most to you at the end of your life?

_____

_____

- Where would you prefer to spend the last stages of your life? Your home? A hospital? Somewhere else?

_____

_____

- What affairs do you need to get in order or talk to your loved ones about?

_____

_____

- Are there any important family milestones for which you would like to be present, if possible?

_____

_____

- Are there any religious or spiritual preferences you have for your end-of-life care?

_____

_____

ICE BREAKERS: How Do I Get Started?

Starting the conversation with your family can be difficult. Below are some of conversation starters to consider using with your loved ones.

- **Medical condition:** Use your medical diagnosis to help start the conversation. "I want you to know my wishes so that you can communicate them for me, if my illness gets worse and I can't speak for myself."
- **Family experience:** Use an example of a family member's experience with serious illness and/or death to help loved ones know about your wishes. "Remember when _____ was on life support after having a heart attack…"
- **News example:** "I read this article on end-of-life care, and it got me thinking about my wishes."
- **Doctor recommendation:** "My doctor provided me this booklet about care planning and suggested I talk about my wishes with you."

You may be surprised at how your family reacts to the discussion. **Remember, you are doing what is best to protect you and them**. If you feel reluctant about having this discussion, you may also include your healthcare provider or another neutral party to assist in starting this conversation.

How do I talk with my healthcare providers about end-of-life issues?

It's important to talk to your physician about end-of-life wishes before a crisis occurs. Here are some things to keep in mind:

- Tell your doctor that you are completing your advance directives, and make sure that he or she is willing to follow your directives. Under the law, physicians are not required to follow these directives if they disagree with them for ethical or moral reasons.
- Give your doctor a copy of your completed directives and include contact information for your appointed healthcare agent.
- Talk about pain management options.

Questions you may wish to ask your physician include:

- ☐ Will you talk openly with me and my family about my illness?
- ☐ What decisions will my family and I have to make, and what kinds of recommendations will you give to help us make these decisions?
- ☐ What will you do if I experience a lot of pain?
- ☐ How will you help us find excellent professionals with special training when we need them (e.g., medical, surgical and palliative care specialists, faith leaders, social workers, etc.)?
- ☐ Will you let me know if treatment stops working so that my family and I can make appropriate decisions?
- ☐ Will you still be available to me even when I am close to the end of my life?

PALLIATIVE CARE: SUPPORTING YOU THROUGH YOUR SERIOUS ILLNESS

PALLIATIVE CARE

Palliative care focuses on the physical, psychological, emotional and spiritual needs of patients who have chronic, debilitating or life-threatening illness. Its goal is ensuring the patient has the best quality of life possible.

Palliative care may include:

- Establishing and navigating goals
- Managing pain and symptoms
- Holding family meetings with the healthcare team
- Participating in and coordinating complex care
- Providing support and help with coping needs
- Providing education
- Identifying someone who can make healthcare decisions if the patient is unable to

If you or a loved one meets the following criteria, you may consider talking with your physician about palliative care:

- Experiencing pain and other symptoms
- Has a chronic illness with frequent hospitalizations
- Decreased functional status
- Decreased quality of life
- Has experienced a hospital stay of five days or more without progress
- Has experienced a prolonged stay in the intensive care unit or repeated transfers back to the unit
- Needs psychological, emotional or spiritual support

For more information about palliative care, contact 217–788–3360.

HOSPICE CARE

As you near the end of your life, hospice care may be right for you.

What is Hospice Care?

It is a specialized type of care for a person who is in the end stage of their life. Hospice focuses on managing a person's pain and other symptoms, so that they can live as comfortably as possible, and have the best quality of life possible, with the time that remains.

The goal of hospice care is comfort rather than cure: it aims to treat a person and their symptoms, rather than the disease itself.

Hospice focuses on the whole person: mental, spiritual and physical. Hospice is family-centered, providing services to assist the entire family through the end stages of their loved one's life.

How to Access Hospice Care

If you are currently a patient in the hospital and would like more information about hospice care, ask a member of your hospital care team.

You do not have to be in the hospital to qualify for hospice care. Memorial Health System offers hospice services through Memorial Home Hospice. If you are interested in receiving hospice information or setting up hospice care, call Memorial Home Hospice at 217–788–4663 or speak with your primary care provider.

With Hospice, Enrolling Sooner Can Often Be Better

Earlier enrollment in hospice can:

- Improve quality of life
- Improve pain and other symptoms
- Improve a person's sense of control
- Provide more quality of time with loved ones
- Reduce hospitalizations
- Prevent a crisis from occurring

NOTICE TO THE INDIVIDUAL SIGNING THE POWER OF ATTORNEY FOR HEALTHCARE

No one can predict when a serious illness or accident might occur. When it does, you may need someone else to speak or make healthcare decisions for you. If you plan now, you can increase the chances that the medical treatment you get will be the treatment you want.

In Illinois, you can choose someone to be your "healthcare agent." Your agent is the person you trust to make healthcare decisions for you if you are unable or do not want to make them yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of agent in writing. The written form is often called an "advance directive." You may use this form or another form, as long as it meets the legal requirements of Illinois. There are many written and online resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing your advance directive.

WHAT ARE THE THINGS I WANT MY HEALTHCARE AGENT TO KNOW?

The selection of your agent should be considered carefully, as your agent will have the ultimate decision-making authority once this document goes into effect, in most instances after you are no longer able to make your own decisions. While the goal is for your agent to make decisions in keeping with your preferences and in the majority of circumstances that is what happens, please know that the law does allow your agent to make decisions to direct or refuse healthcare interventions or withdraw treatment. Your agent will need to think about conversations you have had, your personality, and how you handled important healthcare issues in the past. Therefore, it is important to talk with your agent and your family about such things as:

(i) What is most important to you in your life?
(ii) How important is it to you to avoid pain and suffering?
(iii) If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?
(iv) Would you rather be at home or in a hospital for the last days or weeks of your life?
(v) Do you have religious, spiritual or cultural beliefs that you want your agent and others to consider?
(vi) Do you wish to make a significant contribution to medical science after your death through organ or whole body donation?
(vii) Do you have an existing advance directive, such as a living will, that contains your specific wishes about healthcare that is only delaying your death? If you have another advance directive, make sure to discuss with your agent the directive and the treatment decisions contained within that outline your preferences. Make sure that your agent agrees to honor the wishes expressed in your advance directive.

WHAT KIND OF DECISIONS CAN MY AGENT MAKE?

If there is ever a period of time when your physician determines that you cannot make your own healthcare decisions, or if you do not want to make your own decisions, some of the decisions your agent could make are to:

(i) talk with physicians and other healthcare providers about your condition.
(ii) see medical records and approve who else can see them.
(iii) give permission for medical tests, medicines, surgery or other treatments.
(iv) choose where you receive care and which physicians and others provide it.
(v) decide to accept, withdraw or decline treatments designed to keep you alive if you are near death or not likely to recover. You may choose to include guidelines and/or restrictions to your agent's authority.
(vi) agree or decline to donate your organs or your whole body if you have not already made this decision yourself. This could include donation for transplant, research and/or education. You should let your agent know whether you are registered as a donor in the First Person Consent registry maintained by the Illinois Secretary of State or whether you have agreed to donate your whole body for medical research and/or education.
(vii) decide what to do with your remains after you have died, if you have not already made plans.
(viii) talk with your other loved ones to help come to a decision (but your designated agent will have the final say over your other loved ones).

Your agent is not automatically responsible for your healthcare expenses.

WHOM SHOULD I CHOOSE TO BE MY HEALTHCARE AGENT?

You can pick a family member, but you do not have to. Your agent will have the responsibility to make medical treatment decisions, even if other people close to you might urge a different decision. The selection of your agent should be done carefully, as he or she will have ultimate decision-making authority for your treatment decisions once you are no longer able to voice your preferences. Choose a family member, friend or other person who:

(i) is at least 18 years old;
(ii) knows you well;
(iii) you trust to do what is best for you and is willing to carry out your wishes, even if he or she may not agree with your wishes;
(iv) would be comfortable talking with and questioning your physicians and other healthcare providers;
(v) would not be too upset to carry out your wishes if you became very sick; and
(vi) can be there for you when you need it and is willing to accept this important role.

WHAT IF MY AGENT IS NOT AVAILABLE OR IS UNWILLING TO MAKE DECISIONS FOR ME?

If the person who is your first choice is unable to carry out this role, then the second agent you chose will make the decisions; if your second agent is not available, then the third agent you chose will make the decisions. The second and third agents are called your successor agents and they function as back-up agents to your first-choice agent and may act only one at a time and in the order you list them.

WHAT WILL HAPPEN IF I DO NOT CHOOSE A HEALTHCARE AGENT?

If you become unable to make your own healthcare decisions and have not named an agent in writing, your physician and other healthcare providers will ask a family member, friend or guardian to make decisions for you. In Illinois, a law directs which of these individuals will be consulted. In that law, each of these individuals is called a "surrogate."

There are reasons why you may want to name an agent rather than rely on a surrogate:

(i) The person or people listed by this law may not be who you would want to make decisions for you.
(ii) Some family members or friends might not be able or willing to make decisions as you would want them to.
(iii) Family members and friends may disagree with one another about the best decisions.
(iv) Under some circumstances, a surrogate may not be able to make the same kinds of decisions that an agent can make.

WHAT IF THERE IS NO ONE AVAILABLE WHOM I TRUST TO BE MY AGENT?

In this situation, it is especially important to talk to your physician and other healthcare providers and create written guidance about what you want or do not want, in case you are ever critically ill and cannot express your own wishes. You can complete a living will. You can also write your wishes down and/or discuss them with your physician or other healthcare provider and ask him or her to write it down in your chart. You might also want to use written or online resources to guide you through this process.

WHAT DO I DO WITH THIS FORM ONCE I COMPLETE IT?

Follow these instructions after you have completed the form:

(i) Sign the form in front of a witness. See the form for a list of who can and cannot witness it.
(ii) Ask the witness to sign it, too.
(iii) There is no need to have the form notarized.
(iv) Give a copy to your agent and to each of your successor agents.
(v) Give another copy to your physician.
(vi) Take a copy with you when you go to the hospital.
(vii) Show it to your family and friends and others who care for you.

WHAT IF I CHANGE MY MIND?

You may change your mind at any time. If you do, tell someone who is at least 18 years old that you have changed your mind, and/or destroy your document and any copies. If you wish, fill out a new form and make sure everyone you gave the old form to has a copy of the new one, including, but not limited to, your agents and your physicians.

WHAT IF I DO NOT WANT TO USE THIS FORM?

In the event you do not want to use the Illinois statutory form provided here, any document you complete must be executed by you, designate an agent who is over 18 years of age and not prohibited from serving as your agent, and state the agent's powers, but it need not be witnessed or conform in any other respect to the statutory healthcare power.

If you have questions about the use of any form, you may want to consult your physician, other healthcare provider, and/or an attorney.

POWER OF ATTORNEY FOR HEALTHCARE

THIS POWER OF ATTORNEY REVOKES ALL PREVIOUS POWERS OF ATTORNEY FOR HEALTHCARE.
(You must sign this form and a witness must also sign it before it is valid.)

My name (print your full name): _____
My address:_____

I WANT THE FOLLOWING PERSON TO BE MY HEALTHCARE AGENT
an agent is your personal representative under state and federal law:

Agent name: _____
Agent address: _____
Agent phone number: _____

Please check box if applicable ☐ If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as guardian.

SUCCESSOR HEALTHCARE AGENT(S) (optional):
If the agent I selected is unable or does not want to make healthcare decisions for me, then I request the person(s) I name below to be my successor healthcare agent(s).
Only one person at a time can serve as my agent (add another page if you want to add more successor agent names)

Successor agent #1 name, address and phone number: _____
_____
_____
Successor agent #2 name, address and phone number: _____
_____
_____

MY AGENT CAN MAKE HEALTHCARE DECISIONS FOR ME, INCLUDING:

(i) Deciding to accept, withdraw or decline treatment for any physical or mental condition of mine, including life-and-death decisions.
(ii) Agreeing to admit me to or discharge me from any hospital, home or other institution, including a mental health facility.
(iii) Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.
(iv) Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue or whole body donation, autopsy, cremation and burial.

The above grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of healthcare, including withdrawal of nutrition and hydration and other life-sustaining measures.

I AUTHORIZE MY AGENT TO (please check any one box):

❑ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.
(If no box is checked, then the box above shall be implemented.) OR
❑ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. Starting now, for the purpose of assisting me with my healthcare plans and decisions, my agent shall have complete access to my medical and mental health records, the authority to share them with others as needed, and the complete ability to communicate with my personal physician(s) and other healthcare providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself. OR
❑ Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes. Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or healthcare provider if you have any questions about these statements.

SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES (optional):

☐ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.

☐ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of healthcare. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically in this form.

My signature:_____

Today's date: _____

HAVE YOUR WITNESS AGREE TO WHAT IS WRITTEN BELOW, AND THEN COMPLETE THE SIGNATURE PORTION:

☐ I am at least 18 years old. (check one of the options below):

☐ I saw the principal sign this document, or

☐ The principal told me that the signature or mark on the principal signature line is his or hers.

☐ I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent, or the successor agent(s) by blood, marriage or adoption. I am not the principal's physician, advanced practice registered nurse, dentist, podiatric physician, optometrist, psychologist or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the healthcare facility where the principal is a patient or resident.

Witness printed name:_____

Witness address: _____

Witness signature: _____

Today's date:_____

(c) The statutory short form power of attorney for healthcare (the "statutory healthcare power") authorizes the agent to make any and all healthcare decisions on behalf of the principal which the principal could make if present and under no disability, subject to any limitations on the granted powers that appear on the face of the form, to be exercised in such manner as the agent deems consistent with the intent and desires of the principal. The agent will be under no duty to exercise granted powers or to assume control of or responsibility for the principal's healthcare; but when granted powers are exercised, the agent will be required to use due care to act for the benefit of the principal in accordance with the terms of the statutory healthcare power and will be liable for negligent exercise. The agent may act in person or through others reasonably employed by the agent for that purpose but may not delegate authority to make healthcare decisions. The agent may sign and deliver all instruments, negotiate and enter into all agreements and do all other acts reasonably necessary to implement the exercise of the powers granted to the agent. Without limiting the generality of the foregoing, the statutory healthcare power shall include the following powers, subject to any limitations appearing on the face of the form:

(1) The agent is authorized to give consent to and authorize or refuse, or to withhold or withdraw consent to, any and all types of medical care, treatment or procedures relating to the physical or mental health of the principal, including any medication program, surgical procedures, life-sustaining treatment or provision of food and fluids for the principal.

(2) The agent is authorized to admit the principal to or discharge the principal from any and all types of hospitals, institutions, homes, residential or nursing facilities, treatment centers and other healthcare institutions providing personal care or treatment for any type of physical or mental condition. The agent shall have the same right to visit the principal in the hospital or other institution as is granted to a spouse or adult child of the principal, any rule of the institution to the contrary notwithstanding.

(3) The agent is authorized to contract for any and all types of healt care services and facilities in the name of and on behalf of the principal and to bind the principal to pay for all such services and facilities, and to have and exercise those powers over the principal's property as are authorized under the statutory property power, to the extent the agent deems necessary to pay healthcare costs; and the agent shall not be personally liable for any services or care contracted for on behalf of the principal.

(4) At the principal's expense and subject to reasonable rules of the healthcare provider to prevent disruption of the principal's healthcare, the agent shall have the same right the principal has to examine and copy and consent to disclosure of all the principal's medical records that the agent deems relevant to the exercise of the agent's powers, whether the records relate to mental health or any other medical condition and whether they are in the possession of or maintained by any physician, psychiatrist, psychologist, therapist, hospital, nursing home or other health are provider. The authority under this paragraph (4) applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations thereunder. The agent serves as the principal's personal representative, as that term is defined under HIPAA and regulations thereunder.

(5) The agent is authorized: to direct that an autopsy be made pursuant to Section 2 of "An Act in relation to autopsy of dead bodies," approved August 13, 1965,1 including all amendments; to make a disposition of any part or all of the principal's body pursuant to the Illinois Anatomical Gift Act, 2 as now or hereafter amended; and to direct the disposition of the principal's remains.

(6) At any time during which there is no executor or administrator appointed for the principal's estate, the agent is authorized to continue to pursue an application or appeal for government benefits if those benefits were applied for during the life of the principal.

(d) A physician may determine that the principal is unable to make healthcare decisions for himself or herself only if the principal lacks decisional capacity, as that term is defined in Section 10 of the Health Care Surrogate Act.

(e) If the principal names the agent as a guardian on the statutory short form, and if a court decides that the appointment of a guardian will serve the principal's best interests and welfare, the court shall appoint the agent to serve without bond or security.

Credits

P.A. 85-701, Art. IV, § 4-10, eff. Sept. 22, 1987. Amended by P.A. 85-1395, § 1, eff. Sept. 2, 1988; P.A. 86-736, § 1, eff. Sept. 1, 1989; P.A. 91-240, § 5, eff. Jan. 1, 2000; P.A. 93-794, § 45, eff. July 22, 2004; P.A. 96-1195, § 5, eff. July 1, 2011; P.A. 97-148, § 5, eff. July 14, 2011; P.A. 98-1113, § 5, eff. Jan. 1, 2015; P.A. 99-328, § 5, eff. Jan. 1, 2016; P.A. 100-513, § 340, eff. Jan. 1, 2018.

Formerly Ill.Rev.Stat.1991, ch. 110 ½, ¶ 804-10.

Memorial HEALTH SYSTEM

INFORMATION FOR AGENT

Give this sheet to your appointed agent, so that he or she can fully understand the responsibilities associated with the Durable Power of Attorney for Healthcare.

DUTIES AND RESPONSIBILITIES AS DURABLE POWER OF ATTORNEY FOR HEALTHCARE:

As the healthcare agent, you should be aware of the many responsibilities associated with this role.

You have been appointed Durable Power of Attorney for Healthcare for: _____.
(Individual's name)

Should the above named individual ever become unable to speak for his or herself, you will provide guidance in how decisions are made regarding his or her care. It is your responsibility to follow wishes outlined in the individual's **Power of Attorney for Healthcare** and/or **Living Will** documents.

Your responsibilities may include:

- Working with doctors to ensure the individual receives the medical care he or she wishes
- Consent, refuse or withdraw consent to any care for the individual
- Decisions to admit or discharge the individual from a nursing home
- Request, receive, review and execute releases for medical records
- Decisions about invasive procedures, surgery or dialysis
- Decisions about life-support equipment
- Starting or stopping medications and treatments
- Decisions regarding disposition of the body
- Decisions regarding organ and tissue donation

As the agent, you are only responsible for these decisions if the individual is unable to communicate and unable to make decisions for his or herself. In addition, serving as the Power of Attorney for Healthcare gives you NO CONTROL over, or access to, the individual's financial resources. You are not automatically responsible for the individual's healthcare expenses.

It is very important that you know the individual's wishes and preferences.

Have an open, honest conversation with them to fully understand his or her wishes for healthcare. Write the wishes down and ask if there are individuals he or she would want included in decision-making (children, spiritual leader, close family or friends). Have regular communication with them to make sure his or her wishes have not changed. If the time comes and you need to make his or her healthcare decisions, you will find comfort in knowing exactly what he or she would want.

LIVING WILL

I, _____ born on _____ wish to make it known to those who may be charged with my care that I desire that the moment of my death not be artificially postponed.

If I should have an incurable and irreversible injury, disease or illness that, in my attending physician's judgment, will lead to my imminent death, I direct that any procedures or treatments that would only prolong my dying be withheld or withdrawn. I ask that I be provided only those treatments that will, in my physician's judgment, contribute to my comfort.

In the event of my inability to personally give direction regarding my care, it is my intention that this statement be honored by my family and my physicians as my legal right to refuse medical or surgical treatment. I understand and accept the consequence of my refusal.

Additional directives:

_____

_____

_____

Signed: _____

City, County and State of residence: _____

Date:_____

The declarant is personally known to me, and I believe him or her to be of sound mind. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he or she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant's signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.

Witness:_____Date: _____

Witness:_____Date: _____

ADDITIONAL REFERENCES OR INSTRUCTIONS

Conditions or limitations: _____

Attorney-In-Fact

I hereby appoint:

Name _____

(Relationship)

Address _____

Telephone _____

(Home) (Work) (Other)

to act as my Attorney-In-Fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my Attorney-In-Fact, I authorize the following person to act as my Attorney-In-Fact:

Name _____

(Relationship)

Address _____

Telephone _____

(Home) (Work) (Other)

My Attorney-In-Fact is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my Attorney-In-Fact. **If my wishes are not expressed and are not otherwise known by my Attorney-In-Fact, my Attorney-In-Fact is to act in what he or she believes to be my best interest.**

_____ _____

Signature of Principal *Date*

Affirmation of Witnesses

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this declaration for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is:

- A person appointed as an Attorney-In-Fact by this document • The principal's attending physician or mental health service provider or a relative of the physician or provider • The owner, operator or relative of an owner or operator of a facility in which the principal is a patient or resident • A person related to the principal by blood, marriage or adoption

Witnessed by:

_____ _____ _____

Signature of Witness *Printed Name of Witness* *Date*

_____ _____ _____

Signature of Witness *Printed Name of Witness* *Date*

Acceptance of Appointment as Attorney-In-Fact

I accept this appointment and agree to serve as Attorney-In-Fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental health treatment only while the principal is incapable as determined by a court or two physicians. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner when the principal is not incapable.

_____ _____ _____

Signature of Attorney-In-Fact *Printed Name of Attorney-In-Fact* *Date*

_____ _____ _____

Signature of Alternate Attorney-In-Fact *Printed Name of Alternate Attorney-In-Fact* *Date*

MR178-31

HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

IDPH POLST

State of Illinois
Illinois Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)	Gender ☐ M ☐ F	
Address (street/city/state/ZIPcode)		

A — CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

Check One

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR**

(*Selecting CPR means* **Full Treatment** *in Section B is selected*)

When not in cardiopulmonary arrest, follow orders B and C.

B — MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.

Check One *(optional)*

☐ **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*

☐ **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*

☐ **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Optional Additional Orders _____

C — MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired.

Check One *(optional)*

☐ Long-term medically administered nutrition, including feeding tubes.

☐ Trial period of medically administered nutrition, including feeding tubes.

☐ No medically administered means of nutrition, including feeding tubes.

Additional Instructions (e.g., length of trial period) _____

D — DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

☐ Patient ☐ Agent under health care power of attorney

☐ Parent of minor ☐ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature *(required)*	Name (print)	Date

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature *(required)*	Name (print)	Date

E — Signature of Authorized Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Authorized Practitioner Name *(required)*	Phone
	( ) _____ - _____
Authorized Practitioner Signature *(required)*	Date *(required)*

Form Revision Date - April 2016 **(Prior form versions are also valid.)**

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2016

THIS SIDE FOR INFORMATIONAL PURPOSES ONLY

Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

☐ Health Care Power of Attorney ☐ Living Will Declaration ☐ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- **The completion of a POLST form is always voluntary, cannot be mandated and may be changed at any time.**
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a POLST Form

This POLST form should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another, or
- or there is a substantial change in the patient's health status, or
- or the patient's treatment preferences change, or
- or the patient's primary care professional changes.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at
http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

NOTES

ChooseMemorial.org

Memorial HEALTH SYSTEM

THE JOINT COMMISSION ACCREDITED AND LICENSED IN THE STATE OF ILLINOIS

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