Advance Medical Directives

Living Will & Durable Health Care Power of Attorney

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Your Name (print)

Sponsored by:

Compassionate Care Coalition

The goal of the Compassionate Care Coalition is to have a community prepared to experience the end of life with dignity, meaning and respect for individuals and families. Coalition members are available to present educational sessions and provide information on end of life issues.

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Advance Medical Directives

Introduction

You have the right to choose your medical care, to control your pain and suffering, to receive comfort care, and to use hospice care at the end of your life. Louisiana law lets you say whether or not you would like to have certain kinds of treatments and procedures. The law requires that you clearly say what choices you have made for the end of your life, and how those choices should be followed. The Advance Medical Directive (called a "Living Will") is the document to ensure that your wishes are known and followed.

A second document, the Durable Health Care Power of Attorney, lets you name a person, called an agent, to make health care decisions for you when you can not do so for yourself.

Definitions

Medical Situations – Unconscious/comatose state: You are totally unaware or in a coma, and are not expected to wake up or get well. Life support treatment will only put off the time of death.

Terminal/End-Stage Disease – In spite of treatment, the disease has reached the end-stage. You are not expected to get better and life support treatment will only put off death. Examples are if you have cancer all over your body or advanced diseases of the heart, lungs or kidneys, or advanced dementia, including end-stage Alzheimer's disease.

Treatment Choices

- *Heart and Breathing Restart (CPR or Cardiopulmonary Resuscitation):* Use of drugs and/or electric shock to make your heart beat again and restart breathing after it has stopped.
- *Artificial Breathing:* Using a machine to make your lungs work and breathe for you.
- *Artificial Feeding:* Using tubes to get food and water into the stomach or vein if you can not swallow.
- *Other Treatments:* Things like major surgery, blood transfusion, cancer drugs, medicine for infection, and kidney dialysis.

How to fill out these forms:

- The Living Will and Power of Attorney do not have to be notarized, but doing so may help people accept that you really signed these documents and they contain your wishes.
- You MUST have witnesses to the Living Will but they can not be related to you by blood or marriage and can not be people who may inherit from you upon your death.

What to do after completing the Directives:

- Keep your original signed forms in a safe place that you can get to.
- Talk with your health care agent, family, clergy, doctor and other people important to you about your wishes. Give them copies of these documents.
- Bring a copy with you every time you go to the hospital.
- You may want to file your Living Will with the Secretary of State so it can be easily found. Mail a copy of it, and the $20 fee, to: Louisiana Secretary of State, Publications Division, P. O. Box 94125, Baton Rouge, LA 70804-9125
- You may make changes to your Living Will or cancel a Power of Attorney at any time. To do this, tell those people involved, make new documents, and destroy copies of the old ones.

Living Will

(Advance Medical Directive)

STATE OF LOUISIANA PARISH OF ______________________________

I, ____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

1. If all of the following conditions are present, I state that the procedures checked "NO" in Paragraph 2 below should be withheld or stopped and that I should be allowed to die naturally with only the giving of medication or the doing of any medical procedure that is necessary to provide me with comfort care:

a. I have an incurable injury, disease or illness or I am in a continual deep comatose state with no reasonable chance of getting well; and

b. I have been personally examined by two physicians (at least one of whom shall be my treating physician) and both physicians certify in writing:

1. That my condition is terminal, irreversible and will likely cause my death in the near future, whether or not life-sustaining procedures are used and
2. Application of the procedures would only artificially put off the dying process, or
3. That I am in a continual deep comatose state with no reasonable chance of ever getting well.

2. I make the following directions concerning these procedures. Checking YES means I want the treatment. Checking NO means I do not want the treatment.

YES	NO	
____	____	**Cardiopulmonary Resuscitation** - using drugs and electric shock to keep my heart beating and helping me to breathe
____	____	**Mechanical Breathing** - ventilation; using a machine to help me breathe
____	____	**Major Surgery** - such as removing my gall bladder or part of my intestines
____	____	**Kidney Dialysis** - using machines to clean my blood
____	____	**Chemotherapy** - using drugs to fight cancer
____	____	**Invasive Diagnostic Tests** - such as using a tube to look into my stomach
____	____	**Artificial Nutrition and Hydration** - giving me food and fluid through a tube in my veins, nose or stomach
____	____	**Blood or Blood Products** - such as giving me a transfusion
____	____	**Antibiotics** - using drugs to fight infection
____	____	**Simple Diagnostic Tests** - such as blood tests or x-rays
____	____	**Pain Medications** - even if they make me sleepy or indirectly shorten my life

Living Will
(Advance Medical Directive)- continued

3. If I cannot give directions concerning the use of such life-sustaining procedures, I want this statement to be honored by my family and physician(s) as the last expression of my legal right to accept or refuse medical or surgical treatment and I accept the effects of such refusal.

4. I have also given a Durable Health Care Power of Attorney at the time I made this statement. In case of a disagreement between this statement and the person to whom I have given the right and power to act for me, the following statement shall come first:
(Choose one or the other and check ONLY one)
____ This statement shall come before the Durable Health Care Power of Attorney.
____ My Durable Health Care Power of Attorney shall come before this statement.

5. I understand the full importance of this statement and I am emotionally and mentally able to make this statement.

IN WITNESS HEREOF,
I have signed and acknowledged this statement on this _____day of ________________________, 20_______.

SIGNED: ____

The person signing this statement has been personally known to me and is a person I know to be of sound mind.

____________________________________ ____________________________________
Witness Witness

NOTARY PUBLIC
Louisiana Notary # _________________
My commission expires on: __________

Durable Health Care Power of Attorney

STATE OF LOUISIANA PARISH OF ______________________________

BEFORE ME, the undersigned Notary, and in the presence of the undersigned competent witnesses, came ____ a resident of the full age of majority of ________________________________ Parish, referred to herein as "Principal", who appoints ____a resident of the full age of majority of ______________________________ Parish, as Agent. Agent accepts and agrees to be bound by this specific Power of Attorney.

I. When This Power of Attorney Takes Effect

(Choose one or the other and check ONLY one)

____ My agent can start acting for me as soon as I sign this Power of Attorney.

____ My agent can only start acting for me when I can't let others know what I want.

II. My Agent's Powers

I give my agent all the powers below which are checked "YES", regarding the health care matters that I could exercise on my own behalf. My agent may:

YES NO

____ ____ **Medical Records.** Have access to any medical information in any form about my physical or mental condition, and give or sign any consent forms needed to get it.

____ ____ **Professionals.** Hire, pay and fire any health care professionals my Agent thinks necessary to examine, evaluate or treat me, whether it is for emergency, elective, recuperative, convalescent or other kind of care.

____ ____ **Institutionalization.** Admit me to any health care facility recommended by a qualified health care professional, whether for physical or mental care or treatment, and remove me from such facility at any time, even if against medical advice.

____ ____ **Treatment.** Consent to tests, treatment, medication, surgery, organ transplant or other procedures, and to cancel that consent, even if against medical advice.

____ ____ **Chemical dependency.** Consent to a course of treatment for chemical dependency, whether suspected or diagnosed, and revoke that consent.

____ ____ **Pain Relief.** Consent to pain relief procedures, even if they are unconventional or experimental, even if their use may risk addiction, injury or shorten my life.

____ ____ **Releases.** Release from liability any health care professional or institution that acts on behalf of me in reliance on my Agent.

III. Third Parties

To protect others who deal with my Agent under powers given in this Power of Attorney, people may rely on my Agent's act or signature with the same force and effect as though I were personally present and acting for myself on my behalf, accordingly:

Notice of Amendment or Revocation. No one dealing with my Agent is responsible for knowing I have changed or cancelled this Power of Attorney until a copy of the new Power of Attorney or written notice of the cancellation is delivered to them.

Reliance. Until they receive actual notice that this agency has been changed or cancelled, people may assume that my Agent is acting within the scope of the powers I have given in this Power of Attorney, and that it is still in effect. No one who deals with my Agent is responsible for my Agent's proper use of funds or property.

Information. If asked for information about me, people may give it to my Agent. I release them from any and all legal liability for giving the information my Agent asks for. If that information is privileged, I waive the privilege. My Agent may share that information with whoever my Agent thinks appropriate.

Binding Effect of Copies. People may act on any copy of this Power of Attorney just as if it were the original.

THUS DONE AND SIGNED on this ______ day of ____________________________________, 20_______.

____________________________________	____________________________________
Witness	Principal
____________________________________	____________________________________
Witness	Agent

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NOTARY PUBLIC
Louisiana Notary # __________________
My commission expires on: ___________