ADVANCE DIRECTIVES

Your right to make your health care decisions known at Nebraska Medicine.

Nebraska Medicine

Advance Directives

You have the right as an adult to (1) name another person to make decisions on your behalf if or when you become unable to make them yourself; and (2) give instructions about the types of health care you want or do not want. This booklet will help you consider and express your treatment preferences in an *advance directive.* An advance directive is a statement, usually written, in which you state your choices for health care (sometimes called a *living will)* or name someone (called an *agent* in a *medical power of attorney)* to make such choices on your behalf if you become unable to make your own decision about a medical treatment. The form in this packet is a combined form that lets you to do both in a single document. It is completely up to you whether you want to complete an advance directive.

You may fill out the advance directive form stating your medical preferences *even if you do not name an agent.* Medical professionals will follow your directions in the advance directive without an agent to their best ability, but having a person as your agent to make decisions for you will help medical professionals and those who care for you to make the best decisions in situations that may not be detailed in your advance directive. If your situation changes, or if you simply change your mind, you can make a new form, or revoke the one you have. Tell your doctor or nurse that you want to change your advance directive. It's best to destroy the old document to avoid any confusion. You can complete all or just parts of the advance directive. For example, if you only want to choose an agent in Part One, fill out just that section and then go to Section Five and sign in front of the appropriate witnesses. You are free to complete any other type of advance directive form as long as it is properly witnessed. See Section Five for more details.

Part One names an **agent.** If you can't make your own medical decisions, who would you want to speak on your behalf? This person, your *agent,* should make decisions based on how *you* would make them yourself if you were able. If the agent doesn't know this, they should make decisions in your best interest. An agent can be a family member, a spouse or partner, or a friend; be sure to talk to this person so they know what is important to you. If you choose no one, in Nebraska the default order of surrogates is: spouse, adult child, adult sibling, parent, or another interested person who knows you and/or your wishes.

Part Two describes your treatment goals and wishes. Think about these questions: **What medical treatments would you choose to get more time? How aggressive should medical professionals be to keep you alive?** Choices are provided for you to express your wishes about having, not having, or stopping treatment in certain situations. There is space for you to write any additional wishes.

Note: If you **do not** want CPR, a breathing machine, a feeding tube, or antibiotics, please discuss this with your provider, who can complete a Provider Order for Life Sustaining Treatment (POLST) to ensure that you do not receive treatments you do not want, especially in an emergency. Emergency medical personnel are required to provide you with lifesaving treatment unless they have a medical order specifying some limitation of treatment such as CPR or intubation. If there is no medical order (such as a POLST or do not resuscitate (DNR) order) the emergency medical team will perform CPR as they will not have time to consult an advance directive, your family, agent, or provider.

Part Three describes **limitations of treatments.** Life sustaining treatments are often a bridge to recovery. Sometimes, however, they don't lead to recovery and you may have to keep doing the treatment permanently. Here you can express your wishes about limitations of treatment. These treatments include CPR, breathing machines, feeding tubes and antibiotics. There is space for you to write any additional wishes.

Part Four lets you express your wishes about **organ/tissue donation.** Another place to express this is on a valid driver's license. In order to avoid possible confusion, it is a good idea that your driver's license and your advance directive make the same wishes known about donation.

Part Five You must sign and date the form in the presence of two adult witnesses or a notary. For a medical power of attorney, the document can be witnessed by two adults who are not related to you, an heir, your agent, an insurance provider employee, or your attending physician (only one of them can be an employee of the facility where you get care). A living will, if witnessed, also requires two adults, and cannot be witnessed by an employee of an insurance provider or facility where you get care. You should give copies of the completed form to your agent and alternate agent(s), to your physician, your family and to any health care facility where you reside or at which you are likely to get care.

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This advance directive: (1) names an agent, and/or (2) gives instructions about medical treatments, if I become unable to make or communicate my own decisions. **I have initialed by my preferences for medical treatments in each section below. Any section that is left blank may have a large line written through it, and does not invalidate this advance directive or the contents of any other section.** I understand that my directive should be followed if I have a life threatening injury or medical emergency and am unable to speak for myself at that time.

This space left blank for patient identifiers, scanning labels, etc.
Last Name
First Name
Date of Birth
Date of Completion

Part One: Your Health Care Agent

Your health care agent can make health care decisions for you when you are unable or unwilling to make decisions for yourself. You should pick someone that you trust, who understands your wishes and agrees to act as your agent. Your health care provider may not be your agent unless they are a relative. Your agent may NOT be the owner, operator, employee or contractor of a residential care facility, health care facility or correctional facility where you reside at the time your advance directive is completed.

I appoint _____ , whose contact information is _____ , to be my **primary agent** in any situation in which I lack the capacity to make a medical decision.

I appoint _____ , whose contact information is _____ , to be my **secondary or alternate agent** in any situation that the above named agent is unwilling or unable to act as my agent.

I direct my agent (if assigned), any surrogate decision maker, and my health care providers to comply with the following instructions or limitations described in this document.

Those who may be consulted about medical decisions on my behalf include:_____
_____
_____
_____

Those who should **not** be consulted include:_____
_____
_____
_____

Primary care provider (physician, physician assistant, nurse practitioner):_____
Contact information: _____

I want my advance directive to start:

- ☐ when I cannot make my own decisions.
- ☐ now.
- ☐ when this happens:_____

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Part Two: Health Care Goals and Spiritual Wishes

My overall health goals include:

- ☐ I want to have my life sustained as long as possible by any medical means.
- ☐ I want treatment to sustain my life only if I will:
  - ○ be able to communicate with friends and family.
  - ○ be able to care for myself.
  - ○ live without incapacitating pain.
  - ○ be conscious and aware of my surroundings.
- ☐ I only want treatment directed toward my comfort.

Additional goals, wishes or beliefs I wish to express include:_____
_____
_____
_____

People to notify if I have a life threatening illness:_____
_____
_____
_____

If I am dying, it is important for me to be (check choice):

- ☐ at home.
- ☐ other: _____
- ☐ no preference.

My spiritual care wishes include:

My religion or faith: _____
Place of worship: _____
Contact information:_____
The following items, music, or reading would be a comfort to me: _____
_____

Part Three: Limitations of Treatment

You can decide what kind of treatment you want or don't want if you become seriously ill or are dying. Regardless of the treatment limitations expressed, you have the right to have your pain and symptoms (nausea, fatigue, shortness of breath) managed. Unless treatment limitations are stated, the medical team is expected to do everything that is medically appropriate to try to save your life.

1. If my hearts stops and I stop breathing (choose one):

☐ **I do want** CPR done to try to restart my heart. ☐ **I don't want** CPR done to try to restart my heart.

CPR means cardio (heart)-pulmonary (lung) resuscitation, including vigorous compressions of the chest, use of electrical stimulation, medications to support or restore heart function, and rescue breaths (forcing air into your lungs).

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2. If I am unable to breathe on my own (choose one):

- ☐ **I do want** a breathing machine without any time limits.
- ☐ I want to have a breathing machine for a short time to see if I will survive or get better.
- ☐ **I do not want** a breathing machine for ANY length of time.

"Breathing machine" refers to a device that mechanically moves air into and out of your lungs such as a ventilator.

3. If I am unable to swallow enough food or water to stay alive (choose one):

- ☐ **I do want** a feeding tube without any time limits.
- ☐ I want to have a feeding tube for a short time to see if I will survive or get better.
- ☐ **I do not want** a feeding tube for ANY length of time.

Note: If you are being treated in another state your agent may not automatically have the authority to withhold or withdraw a feeding tube. If you wish to have your agent decide about feeding tubes please check the box below.

☐ I authorize my agent to make decisions about feeding tubes.

4. If I am terminally ill or so ill that I am unlikely to get better (choose one):

- ☐ **I do want** antibiotics or other medication to fight infection.
- ☐ **I do not want** antibiotics or other medication to fight infection.

If you have stated you **do not want** CPR, a breathing machine, a feeding tube, or antibiotics under any circumstances, please discuss this with your primary care provider. Your provider can complete a portable medical order (such as a POLST form) to ensure you don't receive treatments you don't want, particularly in an emergency situation. A POLST form will be honored outside of the hospital setting.

Additional limitations of treatment I wish to include:_____

_____

Part Four: Organ and Tissue Donation

My wishes for organ and tissue donation (check your choices):

- ☐ I consent to donate the following organs and tissues:
  - ☐ any needed organs
  - ☐ any needed tissue (skin, bone, cornea)
  - ☐ **I do not** wish to donate the following organs/tissues: _____
  - ☐ **I do not** want to donate ANY organs or tissues.
  - ☐ I want my health care agent to decide.

- ☐ I wish to donate my body to research or educational program(s). *(Note: you will have to make your own arrangements with a medical school or other program in advance.)*

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Part Five: Signatures or Notary

You must sign in front of two witnesses or a notary public. The following people may not sign as witnesses: spouse, parent, child, grandchild, sibling, presumptive heir, known devisee at the time of the witnessing, attending physician, or agent; or an employee of a life or health insurance provider for the principal. No more than one witness may be an administrator or employee of a health care provider who is caring for or treating the principal.

Patient Signature _____ Date _____

- OR –

Patient Representative Signature _____ Date _____

Declaration of Witness

We declare that the principal is personally known to us, that the principal signed or acknowledged his or her signature on this power of attorney for health care in our presence, that the principal appears to be of sound mind and not under duress or undue influence, and that neither of us nor the principal's attending physician is the person appointed as attorney in fact by this document.

Witness Signature _____ Date _____

Contact Information _____ Date _____

Witness Signature _____ Date _____

Contact Information _____ Date _____

- OR –

On this _____ day of _____ 20____, before me, _____, a notary public in and for_____ County, personally came_____, personally to me known to be the identical person whose name is affixed to the above power of attorney for health care as principal, and I declare that he or she appears in sound mind and not under duress or undue influence, that he or she acknowledges the execution of the same to be his or her voluntary act and deed, and that I am not the attorney in fact or successor attorney in fact designated by this power of attorney for health care.

Witness my hand and notarial seal at _____ in such county the day and year last above written.

_____ _____

(Seal) Signature of Notary Public

The following have a copy of my advance directive (please check):

- ☐ Health care agent
- ☐ Alternate health care agent
- ☐ Doctor/health care provider(s): _____
- ☐ Hospital(s):_____
- ☐ Family member(s): Please list:_____

If you want more information about advance directives, you may ask for help from:

Social Work Department
402.559.4420

Office of Healthcare Ethics
402.552.3647

Spiritual Care Department
402.552.3219

Content in this document is adapted from the Vermont Advance Directive for Health Care and is used with permission from the Vermont Ethics Network. For more information about POLST, go to: www.polst.org

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