

ADVANCED DIRECTIVES WORKSHEETS AND FORMS

1. CHECKLIST

- ☐ **1. REVIEW THE VALUES SURVEY ON PAGE 2**
- ☐ **2. COMPLETE THE MEDICAL SITUATION WORKSHEETS ON PAGES 3-6, IF DESIRED**
- ☐ **3. CHOOSE AN AGENT**, and an alternate agent (if possible).

Choosing an agent is very important because it is the agent's job to make sure your health care wishes are carried out. You will be trusting this person to talk to the doctors, to think about the choices available, and to make decisions that are as close as possible to those you would make yourself. Many people choose an adult child, a spouse, or another close relative, while others prefer a close friend. Your agent should be someone you trust, who knows you well, and who understands your values and beliefs. See page 3 for a list of those who cannot legally be your agent.

- ☐ **4. TALK TO YOUR AGENT — MAKE SURE THEY UNDERSTAND YOUR WISHES.**
- ☐ **5. TALK TO OTHERS FOR GUIDANCE (YOUR DOCTOR, FAMILY MEMBERS, CLERGY)**
- ☐ **6. COMPLETE THE FORM ON PAGES 8-10**
- ☐ **7. SIGN THE DOCUMENT, AND HAVE IT WITNESSED OR NOTARIZED.**
- ☐ **8. MAKE COPIES.**

Make a copy for yourself, and one each for your alternate agent, your doctor, your hospital, and your pastor, priest or rabbi. You might also want to supply copies to your family and lawyer.

- ☐ **9. GIVE THE ORIGINAL TO YOUR AGENT.**

2. VALUES SURVEY

The following questions can help you assess your values concerning medical and end-of-life decisions. You may use these questions to discuss your views with your agent, doctor and family. Talking with them about these values will give them peace of mind when the time arrives for difficult decisions to be made, and will help you make specific choices about medical procedures.

What do you value most about your life?

What brings you joy?

For example:

- Living as long as possible
- Living an active life
- Enjoying the company of family and friends
- Remaining independent and in control

If you find that activity, independence, and/or social interaction are more valuable to you than merely living a long life, then making specific choices concerning medical situations (such as is found in the next section) will be particularly important to you and your family.

Are there certain mental or physical conditions that would make you think that treatments that prolong dying should no longer be used?

For example:

- Lack of awareness of self or surroundings
- Inability to appreciate and continue the important relationships in your life
- Inability to think well enough to make every-day decisions
- Severe pain or discomfort
- Physical damage (such as paralyzed or amputated legs/arms)

It is important to consider some of the possible effects other than death that a severe illness or accident could cause.

How might your personal relationships and responsibilities affect your own medical decision making?

For example:

- The desire to make your own decisions
- The desire to avoid burdening your family with difficult decisions
- Wanting to leave your family with good memories
- Avoiding using up your family savings

Providing your loved ones and caregivers with the information they need to make medical decisions for you is a wonderful gift. It can spare them great anguish, emotional stress and conflict. Even though losing you will be difficult for your family, knowing that they are doing the things you would have wanted will smooth the way.

How do you feel about death and dying?

For example:

- You fear that death will be too prolonged, or that you will be in too much pain.
- You lost someone close to you and you do not want to die that way yourself.
- You want to die with respect and control, and in a setting that you choose as best for you and your family.
- You do not want to suffer for a long time.

All of these questions are very important to consider, along with decisions about medical treatments.

ADDITIONAL INFORMATION

These are the kinds of questions your health care agent may wish to ask the doctors and nurses who are caring for you. Situations in which the Durable Power of Attorney for Health Care are used are almost always very stressful and difficult. Having a list of questions may give your agent the confidence and peace of mind he or she will need to make thoughtful decisions for you.

1. What happens if we just do nothing?
2. What would you do, Doctor, if this was your (wife/husband, child, parent, friend)?
3. You have talked about a complicated treatment plan. Do I have to decide on the whole plan at once or are there separate parts you could tell me about?
4. Please tell me about all of the alternatives and options, one at a time.
5. What are the benefits of each of the alternatives?
6. What are the possible problems with each of the alternatives?
7. What are you hoping to accomplish by doing these treatments? Are you trying to delay death? Are you simply relieving pain?
8. Is there any hope of bringing the patient back to a healthy state?
9. Is this an emergency? Why? Do I have to decide right now or do I have time to think things over?
10. This is what I understand that you have said: Is that right?
11. Is this the easiest/most dignified/least painful way for (this person) to die under the circumstances?

3. MEDICAL SITUATION WORKSHEETS

The following worksheets present four medical situations in which advance directives often are needed. After the description of each situation you will find a checklist of six possible treatments or procedures commonly used by doctors and nurses in hospitals to treat the condition described. Please read each situation carefully, try to imagine yourself in the situation, and decide whether you want, do not want, can't decide, or prefer that the treatment be tried first to determine if it would help you. Put a check mark in one column by each numbered treatment.

This worksheet is not a legal document. It is meant to be a guide for you, as well as for your family, agent, and doctor, not a complete list of all possible medical conditions.

Knowing your wishes in these particular situations, however, will offer guidance in other situations. We recommend that you fill out these worksheets and use this information to fill in Section 2 on the Durable Power of Attorney for Health Care form, and Section 4 on the Living Will form. This information will provide valuable assistance and direction to your agent and doctors in the future.

This section was adapted from Emanuel LL, Emanuel EJ, "The Medical Directive: A New Comprehensive Advance Care Document," *Journal of the American Medical Association*, June 9, '89; 261:3290. Copyright 1990.

SITUATION 1 If my doctor has definitely determined that I have a condition that will shortly cause my death (fatal or terminal condition), and I am unconscious or otherwise unable to speak for myself, then my wishes regarding the use of the following would be:

	I WANT	I DO NOT WANT	I AM UNDECIDED	I WANT TO TRY: If No Clear Improvement, Stop Treatment
1. CARDIOPULMONARY RESUSCITATION (CPR) The use of drugs, artificial breathing, external chest compression, and/or electric shock to restart the heart beating.				
2. MECHANICAL BREATHING Breathing by a machine through a tube inserted through the mouth or nose.				
3. ARTIFICIAL NUTRITION/ HYDRATION Feedings and fluid given through a tube in the veins, nose, or stomach.				
4. PAIN MEDICATIONS (even if they dull consciousness and indirectly shorten my life).				
5. ANTIBIOTICS Drugs to fight infection.				
6. BLOOD OR BLOOD PRODUCTS				

SITUATION 2 If I am unconscious from an accident or severe illness, and there is no known hope of recovering conscious awareness of my environment (irreversible coma or brain death), but machines and drugs could keep my body alive for years, then my wishes regarding the use of the following would be:

	I WANT	I DO NOT WANT	I AM UNDECIDED	I WANT TO TRY: <i>If No Clear Improvement, Stop Treatment</i>
1. CARDIOPULMONARY RESUSCITATION (CPR) The use of drugs, artificial breathing, external chest compression, and/or electric shock to restart the heart beating.				
2. MECHANICAL BREATHING Breathing by a machine through a tube inserted through the mouth or nose.				
3. ARTIFICIAL NUTRITION/ HYDRATION Feedings and fluid given through a tube in the veins, nose, or stomach.				
4. PAIN MEDICATIONS (even if they dull consciousness and indirectly shorten my life).				
5. ANTIBIOTICS Drugs to fight infection.				
6. BLOOD OR BLOOD PRODUCTS				

SITUATION 3 If I become permanently confused or have declined mentally so that I am not capable of caring for myself or being part of any meaningful interaction with family and friends (such as Alzheimer’s Disease, multiple strokes, or dementia), and I become ill, then my wishes regarding the use of the following would be:

	I WANT	I DO NOT WANT	I AM UNDECIDED	I WANT TO TRY: <i>If No Clear Improvement, Stop Treatment</i>
1. CARDIOPULMONARY RESUSCITATION (CPR) The use of drugs, artificial breathing, external chest compression, and/or electric shock to restart the heart beating.				
2. MECHANICAL BREATHING Breathing by a machine through a tube inserted through the mouth or nose.				
3. ARTIFICIAL NUTRITION/ HYDRATION Feedings and fluid given through a tube in the veins, nose, or stomach.				
4. PAIN MEDICATIONS (even if they dull consciousness and indirectly shorten my life).				
5. ANTIBIOTICS Drugs to fight infection.				
6. BLOOD OR BLOOD PRODUCTS				

SITUATION 4 If I am healthy and am in an accident or suffer a sudden illness making me unable to make my wishes known, and my condition is potentially reversible in the opinion of my doctor, then my wishes regarding the use of the following would be:

	I WANT	I DO NOT WANT	I AM UNDECIDED	I WANT TO TRY: <i>If No Clear Improvement, Stop Treatment</i>
1. CARDIOPULMONARY RESUSCITATION (CPR) The use of drugs, artificial breathing, external chest compression, and/or electric shock to restart the heart beating.				
2. MECHANICAL BREATHING Breathing by a machine through a tube inserted through the mouth or nose.				
3. ARTIFICIAL NUTRITION/ HYDRATION Feedings and fluid given through a tube in the veins, nose, or stomach.				
4. PAIN MEDICATIONS (even if they dull consciousness and indirectly shorten my life).				
5. ANTIBIOTICS Drugs to fight infection.				
6. BLOOD OR BLOOD PRODUCTS				

4. INSTRUCTIONS FOR COMPLETING THE LIVING WILL/ DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Please refer to the document starting on the next page and fill it out as you read these instructions carefully.

SECTION I (The Living Will):

The Declaration Relating to the Use of Life-Sustaining Procedures is the legal name given to the Living Will in Iowa.

This statement says that if you are found to have a condition that will cause your death, you do not want your life lengthened by machines, drugs or other treatments. In Iowa law, two doctors must have examined you and certified in writing that you have a condition that will shortly result in death or permanent unconsciousness.

This statement also says that if you have a condition that will cause you to die soon, and you are also unable to make your own decisions due to unconsciousness or loss of ability to think and reason, you give your doctor permission to withhold (not start) or withdraw (stop) treatments that will only prolong dying. It is also clear in this statement that any treatments that make you more comfortable should not be stopped or avoided.

a. The Living Will you just signed does not take effect unless you have been diagnosed with a condition that will result in your death, or are in an irreversible coma and you are not capable of making decisions.

b. Pain medications and feeding by mouth are not included in the definition of "life-sustaining" procedures (treatments that lengthen the process of dying), and therefore will still be given unless you write otherwise.

c. It is **your responsibility** to make sure that your physician and hospital have a copy of your Living Will.

d. You can cancel this Living Will at any time by telling (in any way that you can) your doctor or agent that it is no longer in effect, no matter what your condition.

SECTION II (Durable Power of Attorney For Health Care):

- ☐ **Neatly print or type the name (first, middle initial, last) of your agent on the lines provided. An "attorney-in-fact" is the legal name for your agent.**

The section following the name and address of your agent legally identifies what duties and responsibilities are involved in being a health care agent including:

- a. the power to make health care decisions for you only if a doctor says you are unable to make them yourself
- b. the fact that those decisions must be consistent with your desires
- c. the power to consent to the withholding or withdrawing of medical treatments, even if they are necessary to keep you alive
- d. the power to make these decisions for you for any physical or mental condition as long as they are consistent with verbal or written instructions. Your agent is also given the right to examine your medical records.

- ☐ **Neatly type or print the name, address, and phone number of an alternate agent who will serve if your agent is unable to do so. This is suggested but not required.**
- ☐ **There is a blank area provided for you to write in specific instructions, such as the specific medical treatments that you wish to avoid and in which situations. Use your medical worksheets as a guide.**
- ☐ **Sign your name as you do for any legal document, then neatly type or print your name (as principal, or the person granting the power of attorney or declarant person signing a Living Will) and address on the lines provided under your signature. Your signature must be made in the presence of your witnesses or a notary public.**
- ☐ **You have the option of using a notary, or having two witnesses sign your document. A notary public must observe you signing the document. Likewise, the two witnesses must see you sign and watch each other sign. Make sure that not more than one of your witnesses is related to you. Your doctor or an employee of your doctor cannot be a witness, unless they are also your relative. Also, your agent cannot be a witness.**
- ☐ **Sign your name as Grantor and date the page entitled "Authorization for Release of Protected Health Information to Nominated Health Care Attorney-in-Fact." This allows your proposed agent to obtain necessary medical records when an event occurs to invoke the Durable Power of Attorney for Health Care.**
- ☐ **Record the location of each copy of the Durable Power of Attorney for Health Care and Living Will.**



DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES
(Living Will)
AND
DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS
(Medical Power of Attorney)

I. DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES

If I should have an incurable or irreversible condition that will result either in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery, it is my desire that my life not be prolonged by the administration of life-sustaining procedures. If I am unable to participate in my health care decisions, I direct my attending physician to withhold or withdraw life-sustaining procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

This declaration is subject to any specific instructions or statement of desires I have added in "Additional Provisions" below.

II. POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

I, _____, born _____, designate

(Type or Print) Name of Agent, Street Address, City, State, Zip Code and Phone Number

as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgment of my attending physician, to make those health care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the laws of the State of Iowa, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of my desires and any limitations included in this document.

I hereby revoke all prior Durable Powers Of Attorney for Health Care Decision.

OPTIONAL: If the person designated as agent above is unable to serve, I designate the following person to serve instead:

(Type or Print) Name of Alternate, Street Address, City, State, Zip Code and Phone Number

OPTIONAL: **ADDITIONAL PROVISIONS** - Insert specific instructions or statement of desires (if any):

YES __ NO __ In the event that medical professionals determine that I may be an organ donor, I agree to the use of life-sustaining procedures, including a ventilator, for the sole purpose and time period required to complete the organ donation. Nothing in this paragraph shall be construed to expand or detract from the laws related to anatomical gifts as outlined in the Iowa Code, Chapter 142C. The purpose of this paragraph is to practically and medically make organ donation possible.

Signed this ____ day of _____, ____.

Your Signature (Declarant/Principal)

Address, Street, City, State and Zip

Type or Print Your Name

IMPORTANT NOTE: THIS DOCUMENT MUST BE SIGNED BEFORE A NOTARY PUBLIC OR TWO WITNESSES. SEE REVERSE FOR NOTARY OR WITNESS FORMS. IF YOU WANT TO EXECUTE EITHER A LIVING WILL DECLARATION OR A MEDICAL POWER OF ATTORNEY, BUT NOT BOTH, SEPARATE FORMS ARE AVAILABLE FROM THE IOWA STATE BAR ASSOCIATION. IF YOU HAVE QUESTIONS REGARDING THIS FORM OR NEED ASSISTANCE TO COMPLETE IT, YOU SHOULD CONSULT AN ATTORNEY.

NOTARY PUBLIC FORM

STATE OF _____, COUNTY OF _____ SS:
This document was acknowledged before me on _____, by _____

_____, Notary Public

WITNESS FORM

We, the undersigned, hereby state that we signed this document in the presence of each other and the Declarant/Principal and we witnessed the signing of the document by the Declarant/Principal or by another person acting on behalf of the Declarant/Principal at the direction of the Declarant/Principal; that neither of us is appointed as attorney in fact by this document; that neither of us are health care providers who are presently treating the Declarant/Principal, or employees of such a health care provider. We further state that we are both at least 18 years of age, and that at least one of us is not related to the Declarant/Principal by blood, marriage or adoption.

Signature of First Witness

Signature of Second Witness

Type or Print Name of Witness

Type or Print Name of Witness

Street Address, City, State and Zip Code

Street Address, City, State and Zip Code

GENERAL INFORMATION REGARDING THIS DOCUMENT

1. "Health care" means any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition. "Life-sustaining procedure" means any medical procedure, treatment, or intervention which utilizes mechanical or artificial means to sustain, restore, or supplement a spontaneous vital function, and when applied to a person in a terminal condition, would serve only to prolong the dying process. "Life sustaining procedure" does not include administration of medication or performance of any medical procedure deemed necessary to provide comfort care or to alleviate pain.
2. The terms "health care" and "life-sustaining procedure" include nutrition and hydration (food and water) only when provided parenterally or through intubation (intravenously or by feeding tube). Thus, this document authorizes withholding nutrition or hydration that is provided intravenously or by feeding tube. If this is not what you want, you should set forth your specific instructions in the space provided on page 1.
3. The following individuals shall not be designated as the attorney in fact to make health care decisions under a durable power of attorney for health care:
 - a. A health care provider attending the principal on the date of execution.
 - b. An employee of such a health care provider unless the individual to be designated is related to the principal by blood, marriage, or adoption within the third degree of consanguinity.
4. The power of attorney for health care decisions or the declaration relating to use of life-sustaining procedures may be revoked at any time and in any manner by which the principal/declarant is able to communicate the intent to revoke, without regard to mental or physical condition. A revocation is only effective as to the attending health care provider upon its communication to the provider by the principal/declarant or by another to whom the principal/declarant has communicated the revocation.
5. It is the responsibility of the principal/declarant to provide the attending health care provider with a copy of this document.
6. A declaration relating to use of life-sustaining procedures will be given effect only when the declarant's condition is determined to be terminal or the declarant is in a state of permanent unconsciousness, and the declarant is not able to make treatment decisions.

SUGGESTIONS AFTER FORM IS PROPERLY SIGNED, WITNESSED OR NOTARIZED

1. Place original in a safe place known and accessible to family members or close friends.
2. Provide a copy to your doctor.
3. Provide a copy(s) to family member(s).
4. Provide a copy to the designated attorney in fact (agent) and to alternate designated attorneys in fact (if any).

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION TO NOMINATED HEALTH CARE ATTORNEY-IN-FACT

Pursuant to the terms of a Durable Power of Attorney, Health Care Decisions, (or Combined Living Will and Medical Power of Attorney) (HCPOA) dated _____, in which the undersigned is the grantor, the power becomes effective in the event of my disability or incapacity.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company and the Medical Information Bureau, Inc., or other health care clearinghouse that has provided treatment or services to me or that has paid for or is seeking payment from me for such services, to give, disclose, and release to the person or persons designated in this document to act as my agent such of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition

(including all specially protected health information relating to each of the following conditions specifically authorized by me to be disclosed by marking the box with an "X" or a check mark:

- ☐ sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), and human immunodeficiency virus (HIV);
- ☐ behavioral and mental health; and
- ☐ alcohol, drug and other substance abuse)

Signature of Principal

Date

relating to my ability to make health care decisions. The purpose of this request is to assist in determining whether the person designated to act as my agent should act as my agent. This authorization expires when I die or when revoked by me by a written revocation signed by me and delivered to the entity from which information is being requested prior to the time information is being requested.

I understand I can revoke this authorization by delivering a written statement of revocation to any entity I have authorized to give, disclose and release information. The revocation is effective only as to those entities to whom the written statement revocation is given and only after the time of delivery. I also understand that I have the right to inspect the disclosed information at any time. My treatment, payment, enrollment or eligibility for benefits with an entity that I have authorized to release information is not conditioned on my signing this authorization. I know that once the information I have authorized to be released is released it is subject to re-disclosure by the recipient and is no longer protected by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto, as amended from time to time.

THE AUTHORITY TO ACT AS PERSONAL REPRESENTATIVE

In addition to the other powers granted by the HCPOA, I grant to my agent the power and authority to serve as my personal representative for all purposes of the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and its regulations (HIPAA) during any time that my agent (hereinafter referred to in subsequent clauses of this paragraph as my "HIPAA personal representative") is exercising authority under this document.

Pursuant to HIPAA, I specifically authorize my HIPAA personal representative to request, receive and review any information regarding my physical or mental health, including without limitation all HIPAA-protected health information, medical and hospital records; to execute on my behalf any authorizations, releases, or other documents that may be required in order to obtain this information and to consent to the disclosure of this information. I further authorize my HIPAA personal representative to execute on my behalf any documents necessary or desirable to implement the health care decisions that my HIPAA personal representative is authorized to make under the HCPOA.

Dated this _____ day of _____, _____.

, Grantor