Advance Directives Packet

Swedish Covenant Hospital is pleased to provide you with information concerning Advance Directives. In Illinois the Advance Directives are: Power of Attorney for Healthcare, Living Will, and the Mental Health Treatment Preference Declaration. You may also sign a Do Not Resuscitate (DNR) Advance Directive that indicates to your doctors and nurses your wishes about receiving cardiopulmonary resuscitation (CPR) and life-sustaining treatments.

The Statement of Illinois Law on Advance Directives and DNR Orders is included so that you will have a description of the various advance directives.

Please read and consider this matter and discuss the issues with your family and those close to you. If you have any questions regarding medical, ethical, or legal issues please consult your physician, clergyman, or legal advisor.
STATEMENT OF ILLINOIS LAW ON ADVANCE DIRECTIVES AND DNR ORDERS

You have the right to make decisions about the health care you get now and in the future. An advance directive is a written statement you prepare about how you want your medical decisions to be made in the future, if you are no longer able to make them for yourself. A do not resuscitate order (DNR order) is a medical treatment order that says cardiopulmonary resuscitation (CPR) will not be used if your heart and/or breathing stops.

Federal law requires that you be told of your right to make an advance directive when you are admitted to a health-care facility. Illinois law allows for the following three types of advance directives: (1) health care power of attorney; (2) living will; and (3) mental health treatment preference declaration. In addition, you can ask your physician to work with you to prepare a DNR order. You may choose to discuss with your health-care professional and/or attorney these different types of advance directives as well as a DNR order. After reviewing information regarding advance directives and a DNR order, you may decide to make more than one. For example, you could make a health care power of attorney and a living will.

If you have one or more advance directives and/or a DNR order, tell your health-care professional and provide them with a copy. You may also want to provide a copy to family members, and you should provide a copy to those you appoint to make these decisions for you.

State law provides copies of sample advance directives forms. In addition, this webpage provides a copy of these forms and a copy of the Illinois Department of Public Health (IDPH) Uniform Do Not Resuscitate (DNR) Advance Directive.

Health Care Power of Attorney

The health care power of attorney lets you choose someone to make health-care decisions for you in the future, if you are no longer able to make these decisions for yourself. You are called the "principal" in the power of attorney form and the person you choose to make decisions is called your "agent." Your agent would make health-care decisions for you if you were no longer able to make these decisions for yourself. So long as you are able to make these decisions, you will have the power to do so. You may use a standard health care power of attorney form or write your own. You may give your agent specific directions about the health care you do or do not want.

The agent you choose cannot be your health-care professional or other health-care provider. You should have someone who is not your agent witness your signing of the power of attorney.

The power of your agent to make health-care decisions on your behalf is broad. Your agent
would be required to follow any specific instructions you give regarding care you want provided or withheld. For example, you can say whether you want all life-sustaining treatments provided in all events; whether and when you want life-sustaining treatment ended; instructions regarding refusal of certain types of treatments on religious or other personal grounds; and instructions regarding anatomical gifts and disposal of remains. Unless you include time limits, the health care power of attorney will continue in effect from the time it is signed until your death. You can cancel your power of attorney at any time, either by telling someone or by canceling it in writing. You can name a backup agent to act if the first one cannot or will not take action. If you want to change your power of attorney, you must do so in writing.

**Living Will**

A *living will* tells your health-care professional whether you want death-delaying procedures used if you have a terminal condition and are unable to state your wishes. A living will, unlike a health care power of attorney, only applies if you have a terminal condition. A terminal condition means an incurable and irreversible condition such that death is imminent and the application of any death delaying procedures serves only to prolong the dying process.

Even if you sign a living will, food and water cannot be withdrawn if it would be the only cause of death. Also, if you are pregnant and your health-care professional thinks you could have a live birth, your living will cannot go into effect.

You can use a standard living will form or write your own. You may write specific directions about the death-delaying procedures you do or do not want.

Two people must witness your signing of the living will. Your health-care professional cannot be a witness. It is your responsibility to tell your health-care professional if you have a living will if you are able to do so. You can cancel your living will at any time, either by telling someone or by canceling it in writing.

If you have both a health care power of attorney and a living will, the agent you name in your power of attorney will make your health-care decisions unless he or she is unavailable.

**Mental Health Treatment Preference Declaration**

A *mental health treatment preference declaration* lets you say if you want to receive electroconvulsive treatment (ECT) or psychotropic medicine when you have a mental illness and are unable to make these decisions for yourself. It also allows you to say whether you wish to be admitted to a mental health facility for up to 17 days of treatment.

You can write your wishes and/or choose someone to make your mental health decisions for you. In the declaration, you are called the "principal" and the person you choose is called an "attorney-in-fact." Neither your health-care professional nor any employee of a health-care facility in which you reside may be your attorney-in-fact. Your attorney-in-fact must accept the appointment in writing before he or she can start making decisions regarding your mental health treatment. The attorney-in-fact must make decisions consistent with any
desires you express in your declaration unless a court orders differently or an emergency threatens your life or health.

Your mental health treatment preference declaration expires three years from the date you sign it. Two people must witness you signing the declaration. The following people may not witness your signing of the declaration: your health-care professional; an employee of a health-care facility in which you reside; or a family member related by blood, marriage or adoption. You may cancel your declaration in writing prior to its expiration as long as you are not receiving mental health treatment at the time of cancellation. If you are receiving mental health treatment, your declaration will not expire and you may not cancel it until the treatment is successfully completed.

**Do-Not-Resuscitate Order**

You may also ask your health-care professional about a *do-not-resuscitate order* (DNR order). A DNR order is a medical treatment order stating that cardiopulmonary resuscitation (CPR) will not be attempted if your heart and/or breathing stops. The law authorizing the development of the form specifies that an individual (or his or her authorized legal representative) may execute the IDPH Uniform DNR Advance Directive directing that resuscitation efforts shall not be attempted. Therefore, a DNR order completed on the IDPH Uniform DNR Advance Directive contains an advance directive made by an individual (or legal representative), and also contains a physician’s order that requires a physician’s signature.

Before a DNR order may be entered into your medical record, either you or another person (your legal guardian, health care power of attorney or surrogate decision maker) must consent to the DNR order. This consent must be witnessed by one person who is 18 years or older. If a DNR order is entered into your medical record, appropriate medical treatment other than CPR will be given to you. This webpage provides a copy of the Illinois Department of Public Health (IDPH) Uniform Do Not Resuscitate (DNR) Advance Directive that may be used by you and your physician. This webpage also provides a link to guidance for individuals, health-care professionals and health-care providers concerning the IDPH Uniform DNR Advance Directive.

**What happens if you don't have an advance directive?**

Under Illinois law, a health care “surrogate” may be chosen for you if you cannot make health-care decisions for yourself and do not have an advance directive. A health care surrogate will be one of the following persons (in order of priority): guardian of the person, spouse, any adult child(ren), either parent, any adult brother or sister, any adult grandchild (ren), a close friend, or guardian of the estate.

The surrogate can make all health-care decisions for you, with certain exceptions. A health care surrogate cannot tell your health-care professional to withdraw or withhold life-sustaining treatment unless you have a "qualifying condition," which is a terminal condition, permanent unconsciousness, or an incurable or irreversible condition. A "terminal condition" is an incurable or irreversible injury for which there is no reasonable prospect of cure or recovery, death is imminent and life-sustaining treatment will only prolong the dying
process. "Permanent unconsciousness" means a condition that, to a high degree of medical certainty, will last permanently, without improvement; there is no thought, purposeful social interaction or sensory awareness present; and providing life-sustaining treatment will only have minimal medical benefit. An "incurable or irreversible condition" means an illness or injury for which there is no reasonable prospect for cure or recovery, that ultimately will cause the patient's death, that imposes severe pain or an inhumane burden on the patient, and for which life-sustaining treatment will have minimal medical benefit.

Two doctors must certify that you cannot make decisions and have a qualifying condition in order to withdraw or withhold life-sustaining treatment. If your health care surrogate decision maker decides to withdraw or withhold life-sustaining treatment, this decision must be witnessed by a person who is 18 years or older. A health care surrogate may consent to a DNR order, however, this consent must be witnessed by one individual 18 years or older.

A health care surrogate, other than a court-appointed guardian, cannot consent to certain mental health treatments, including treatment by electroconvulsive therapy (ECT), psychotropic medication or admission to a mental health facility. A health care surrogate can petition a court to allow these mental health services.

Final Notes

You should talk with your family, your health-care professional, your attorney, and any agent or attorney-in-fact that you appoint about your decision to make one or more advance directives or a DNR order. If they know what health care you want, they will find it easier to follow your wishes. If you cancel or change an advance directive or a DNR order in the future, remember to tell these same people about the change or cancellation.

No health-care facility, health-care professional or insurer can make you execute an advance directive or DNR Order as a condition of providing treatment or insurance. It is entirely your decision. If a health-care facility, health-care professional or insurer objects to following your advance directive or DNR order then they must tell you or the individual responsible for making your health-care decisions. They must continue to provide care until you or your decision maker can transfer you to another health-care provider who will follow your advance directive or DNR order.

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Questions or Comments

http://www.idph.state.il.us/public/books/advdir4.htm

5/1/2013
Notice to the Individual Signing the Illinois Statutory Short Form Power of Attorney for Health Care.
Please Read This Notice Carefully.

The form that you will be signing is a legal document. It is governed by the Illinois Power of Attorney Act. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.

The purpose of this power of attorney is to give your designated “agent” broad powers to make health care decisions for you, including the power to require, consent to, or withdraw treatment for any physical or mental condition, and to admit you or discharge you from any hospital, home, or other institution. You may name successor agents under this form, but you may not name co-agents.

This form does not impose a duty upon your agent to make such health care decisions, so it is important that you select an agent who will agree to do this for you and who will make those decisions as you would wish. It is also important to select an agent whom you trust, since you are giving that agent control over your medical decision-making, including end-of-life decisions. Any agent who does act for you has a duty to act in good faith for your benefit and to use due care, competence, and diligence. He or she also must act in accordance with the law and with the statements in this form. Your agent must keep a record of all significant actions taken as your agent.

Unless you specifically limit the period of time that this power of attorney will be in effect, your agent may exercise the powers given to him or her throughout your lifetime, even after you become disabled. A court, however, can take away the powers of your agent if it finds that the agent is not acting properly. You also may revoke this power of attorney if you wish.

The powers you give your agent, your right to revoke those powers, and the penalties for violating the law are explained more fully in Sections 4-5, 4-6, and 4-10(c) of the Illinois Power of Attorney Act. This form is a part of that law. The “NOTE” paragraphs throughout this form are instructions.

You are not required to sign this power of attorney, but it will not take effect without your signature. You should not sign it if you do not understand everything in it, and what your agent will be able to do if you do sign it.

Please put your initials on the following line indicating that you have read this notice.

(principal’s initials)

9/2011
Illinois Statutory Short Form
Power of Attorney for Health Care

1. I, ________________________________
   (insert name, date of birth and address of principal)
   hereby revoke all prior powers of attorney for health care executed by me and appoint:
   ________________________________
   (insert name and address of agent)

   (NOTE: You may not name co-agents using this form.) as my attorney-in-fact (my “agent”) to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue.

   A. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others.

   B. Effective upon my death, my agent has the full power to make an anatomical gift of the following (initial one):

   (NOTE: Initial one. In the event none of the options are initialed, then it shall be concluded that you do not wish to grant your agent any such authority.)

   _____ Any organs, tissues or eyes suitable for transplantation or used for research or education.

   _____ Specific organs: ________________________________

   _____ I do not grant my agent authority to make any anatomical gifts.

   C. My agent also shall have full power to authorize an autopsy and direct the disposition of my remains. I intend for this power of attorney to be in substantial compliance with Section 10 of the Disposition of Remains Act. All decisions made by my agent with respect to the disposition of my remains, including cremation, shall be binding. I hereby direct any cemetery organization, business operating a crematory or columbarium or both, funeral director or embalmer, or funeral establishment who receives a copy of this document to act under it.

   D. I intend for the person named as my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records, including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and regulations thereunder. I intend for the person named as my agent to serve as my “personal representative” as that term is defined under HIPAA and regulations thereunder.

   (i) The person named as my agent shall have the power to authorize the release of information governed by HIPAA to third parties.

   (ii) 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 Informational Bureau Inc., or any other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment for me for such services to give, disclose and release to the person named as my agent, without restriction, all of my individually identifiable health information and medical records, regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, drug or alcohol abuse, and mental illness (including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act).
(iii) The authority given to the person named as my agent shall supersede any prior agreement that I may have with my health care providers to restrict access to, or disclosure of, my individually identifiable health information. The authority given to the person named as my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

(NOTE: 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 health care, including withdrawal of food and water and other life-sustaining measures, if your agent believes such action would be consistent with your intent and desires. If you wish to limit the scope of your agent’s powers or prescribe special rules or limit the power to make an anatomical gift, authorize autopsy or dispose of remains, you may do so in the following paragraphs.)

2. The powers granted above shall not include the following powers or shall be subject to the following rules or limitations:

(NOTE: Here you may include any specific limitations you deem appropriate, such as: your own definition of when life-sustaining measures should be withheld; a direction to continue food and fluids or life-sustaining treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electro-convulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc.)

注：生命维持治疗的主体是一个特别重要的问题。为了方便你处理有关生命维持治疗的事项，以下是一些有关停止或移除生命维持治疗的规定。如果你同意其中任何一条规定，你可以在第一行写上这个规定，但不能超过一条。这些规定作为你代理人进行决策的指导。

I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

Initialed________

I want my life to be prolonged and I want life-sustaining treatment to be provided or continued, unless I am, in the opinion of my attending physician, in accordance with reasonable medical standards at the time of reference, in a state of “permanent unconsciousness” or suffer from an “incurable or irreversible condition” or “terminal condition,” as those terms are defined in Section 4-4 of the Illinois Power of Attorney Act. If and when I am in any one of these states or conditions, I want life-sustaining treatment to be withheld or discontinued.

Initialed________
I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards without regard to my condition, the chances I have for recovery or the cost of the procedures.

Initialed________

(NOTE: This power of attorney may be amended or revoked by you in the manner provided in Section 4-6 of the Illinois Power of Attorney Act.

3. ( ) This power of attorney shall become effective on________________________________________

________________________________________

(NOTE: Insert a future date or event during your lifetime, such as a court determination of your disability or a written determination by your physician that you are incapacitated, when you want this power to first take effect.)

(NOTE: If you do not amend or revoke this power, or if you do not specify a specific ending date in paragraph 4, it will remain in effect until your death; except that your agent will still have the authority to donate your organs, authorize an autopsy, and dispose of your remains after your death, if you grant that authority to your agent.)

4. ( ) This power of attorney shall terminate on________________________________________

________________________________________

(NOTE: Insert a future date or event, such as a court determination that you are not under a legal disability or a written determination by your physician that you are not incapacitated, if of your disability, when you want this power to terminate prior to your death.)

(NOTE: You cannot use this form to name co-agents. If you wish to name successor agents, insert the names and addresses of the successors in paragraph 5.)

5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent:

__________________________________________________________________________

For purposes of this paragraph 5, a person shall be considered to be incompetent if and while the person is a minor, or an adjudicated incompetent or disabled person, or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.

(NOTE: If you wish to, you may name your agent as guardian of your person if a court decides that one should be appointed. To do this, retain paragraph 6, and the court will appoint your agent if the court finds that this appointment will serve your best interests and welfare. Strike out paragraph 6 if you do not want your agent to act as guardian.)

6. If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.
Illinois Statutory Short Form Power of Attorney for Health Care Page 4

7. I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Dated: ____________________________

Signed ____________________________

(principal’s signature or mark principal)

The principal has had an opportunity to review the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence. The undersigned witness certifies that the witness is not: (a) the attending physician or mental health service provider or a relative of the physician or provider; (b) an owner, operator, or relative of an owner or operator of a health care facility in which the principal is a patient or resident; (c) a parent, sibling, descendant, or any spouse of such parent, sibling, or descendant of either the principal or any agent or successor agent under the foregoing power of attorney, whether such relationship is by blood, marriage, or adoption; or (d) an agent or successor agent under the foregoing power of attorney.

_________________________________  ____________________________

(witness signature)  (print witness name)

______________________________

(street address)

______________________________

(city, state, ZIP)

(NOTE: You may, but are not required to, request your agent and successor agents to provide specimen signatures below. If you include specimen signatures in this power of attorney, you must complete the certification opposite the signatures of the agents.)

I certify that the signatures of my agent (and successors) are correct.

_________________________________  ____________________________

(agent)  (principal)

_________________________________  ____________________________

(successor agent)  (principal)

_________________________________  ____________________________

(successor agent)  (principal)

(NOTE: The name, address and phone number of the person preparing this form or who assisted the principal in completing this form is optional.)

_________________________________

(name of preparer)

______________________________

(address)

______________________________

(phone)

Rev 5/2012
Living Will

DECLARATION

This declaration is made this _________ day of ______________________ (month, year).

I, ____________________________, born on _______________, being of sound mind, willfully and voluntarily make known my desires that my moment of death shall not be artificially postponed.

If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such death delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Signed__________________________

City, County and State of Residence__________________________

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__________________________

Witness__________________________

History
(Source: P.A. 85-1209.)

Annotations
Note. This section was Ill.Rev.Stat., Ch. 110 1/2, Para. 703.

Rev 5/2012
Declaration for Mental Health Treatment

I, ________________________________, born on __________, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by two physicians or the court that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. “Mental health treatment” means electroconvulsive treatment, treatment of mental illness with psychotropic medication, and admission to and retention in a health care facility for a period up to 17 days.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

________________________________________________________________________________________________________________________________________

PSYCHOTROPIC MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

_______ I consent to the administration of the following medications:

________________________________________________________________________________________________________________________________________

_______ I do not consent to the administration of the following medications:

________________________________________________________________________________________________________________________________________

Conditions or limitations:

________________________________________________________________________________________________________________________________________

ELECTROCONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

_______ I consent to the administration of electroconvulsive treatment.

_______ I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations: _________________________________________________________________

______________________________________________________________

(continued)
ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding admission to and retention in a health care facility for mental health treatment are as follows:

_____ I consent to being admitted to a health care facility for mental health treatment.

_____ I do not consent to being admitted to a health care facility for mental health treatment.

This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.

Conditions or limitations:

_________________________________________________________________________________

_________________________________________________________________________________

SELECTION OF PHYSICIAN (optional)

If it becomes necessary to determine if I have become incapable of giving or withholding informed consent for mental health treatment, I choose Dr. _____________________________ of _____________________________ to be one of the two physicians who will determine whether I am incapable. If that physician is unavailable, that physician’s designee shall determine whether I am incapable.

ADDITIONAL REFERENCES OR INSTRUCTIONS

_________________________________________________________________________________

_________________________________________________________________________________

Conditions or limitations:

_________________________________________________________________________________

_________________________________________________________________________________

ATTORNEY-IN-FACT

I hereby appoint:

NAME _____________________________

ADDRESS _____________________________

TELEPHONE# _____________________________

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.

(continued)
Declaration for Mental Health Treatment

ATTORNEY-IN-FACT (continued)

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____________________________________________________________________________________

ADDRESS________________________________________________________________________________

TELEPHONE#______________________________________________________________________________

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; or

A person related to the principal by blood, marriage or adoption.

Witnessed By:

________________________________________________________ (Signature of Witness/Date) (Printed Name of Witness)

________________________________________________________ (Signature of Witness/Date) (Printed Name of Witness)

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/Date) (Printed Name of Witness)

________________________________________________________ (Signature of Attorney-in-fact/Date) (Printed Name of Witness)

(continued)
NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about three types of mental health treatment: psychotropic medication, electroconvulsive therapy, and short-term (up to 17 days) admission to a treatment facility. The instructions that you include in this declaration will be followed only if two physicians or the court believes that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

You may also appoint a person as your attorney-in-fact to make these treatment decisions for you if you become incapable. The person you appoint has a duty to act consistent with your desires as stated in this document or, if your desires are not stated or otherwise made known to the attorney-in-fact, to act in a manner consistent with what the person in good faith believes to be in your best interest. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your attorney-in-fact at any time.

This document will continue in effect for a period of three years unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

You have the right to revoke this document in whole or in part at any time you have been determined by a physician to be capable of giving or withholding informed consent for mental health treatment. A revocation is effective when it is communicated to your attending physician in writing and is signed by you and a physician. The revocation may be in a form similar to the following:

REVOCATION

I, ____________________________________________________________________________, willfully and voluntarily revoke my declaration for mental health treatment as indicated

[ ] I revoke my entire declaration

[ ] I revoke the following portion of my declaration

__________________________________________________________________________________

__________________________________________________________________________________

Date ____________________ Signed ____________________ (Signature of principal)

I, Dr. ____________________________________________________________________________, have evaluated the principal and determined that he or she is capable of giving or withholding informed consent for mental health treatment.

Date ____________________ Signed ____________________ (Signature of physician)

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.

History
(Source: P.A. 89-439, § 75.)

Rev 5/2012
Illinois Department of Public Health

UNIFORM DO-NOT-RESUSCITATE (DNR) ADVANCE DIRECTIVE

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

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

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. See also Guidance for Health Care Professionals at http://www.idph.state.il.us/public/books/advln.htm.

Patient Last Name

Patient First Name

MI

Date of Birth (mm/dd/yy)

Gender

☐ M ☐ F

Address (street/city/state/ZIP code)

CARDIOPULMONARY RESUSCITATION (CPR) Patient has no pulse and is not breathing.

☐ Attempt Resuscitation/CPR (Selecting CPR means Intubation and Mechanical Ventilation in Section B is selected)

☐ Do Not Attempt Resuscitation/DNR

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

MEDICAL INTERVENTIONS Patient has pulse and/or is breathing.

☐ Comfort Measures Only (Allow Natural Death). Relieve pain and suffering through the use of medication by appropriate route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location. Treatment Plan: Maximize comfort through symptom management.

☐ Limited Additional Interventions In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP, BIPAP). Transfer to hospital if indicated. Generally avoid the intensive care unit. Treatment Plan: Provide basic medical treatments.

☐ Intubation and Mechanical Ventilation In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated. Treatment Plan: Life support measures, including intubation, in the intensive care unit.

☐ Additional Orders

ARTIFICIALLY ADMINISTERED NUTRITION Offer food by mouth, if feasible and as desired.

☐ No artificial nutrition by tube.

☐ Defined trial period of artificial nutrition by tube.

☐ Long-term artificial nutrition by tube.

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

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

SIGNATURE OF ATTENDING PHYSICIAN

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 Attending Physician Name (required)

Attending Physician Signature (required)

Phone

Printed Name

Date (required)
The Illinois Department of Public Health (IDPH) Uniform Do Not Resuscitate (DNR) Advance Directive is always voluntary and is for persons with advanced or serious illness or frailty. 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 form (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

☐ 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 Uniform Do Not Resuscitate (DNR) Advance Directive Form

- The completion of a DNR form is always voluntary, cannot be mandated and may be changed at any time.
- A DNR form should reflect current preferences of persons with advanced or serious illness or frailty. Also, encourage completion of a POAHC.
- Verbal/telephone orders are acceptable with follow-up signature by attending physician 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 Do Not Resuscitate (DNR) Advance Directive Form

This DNR form should be reviewed periodically and if:
- The patient is transferred from one care setting or care level to another;
- There is a substantial change in the patient's health status;
- The patient's treatment preferences change;
- The patient's primary care professional changes.

Voiding or revoking a Do Not Resuscitate (DNR) Advance Directive Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a DNR form requires completion of a new DNR form.
- Draw line through sections A through E and write "VOID" in large letters if any DNR 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://www.idph.state.il.us/public/books/advcm.htm

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