Advance Directives: What you need to know

Advance Directives are the legal documents that provide instructions about your healthcare wishes if you have lost the capacity to speak for yourself.

Advance Directives authorized by Ohio state law consist of two documents:

1. **Ohio Durable Power of Attorney for Healthcare**: The person you designate to ensure that your wishes about life-sustaining treatment are carried out when you cannot make decisions about your health care. Also called your healthcare proxy.

2. **Ohio Living Will Declaration:** The documented decisions about life-sustaining treatments you may or may not want if you are not capable of making decisions.

They are valid only if:

- They are acknowledged before a notary public.

  OR

- They are signed by at least two adult witnesses present when you sign or who acknowledge your signature. No person who is related to you by blood, marriage, or adoption OR who is your doctor or the administrator of your healthcare facility can be a witness.

Keep them accessible. Keep a copy of your Advance Directive in a place that is easily accessible and provide your doctors, your healthcare proxy, and loved ones with copies.

Update them when you have a change in health or every few years. Your wishes may change over time.

Do Not Resuscitate (DNR) Comfort Care Order:

Must be signed by a doctor, NP, or PA (with a collaborating MD listed) and is considered a medical order. This is in effect during a medical emergency. If you do not have one then emergency medical providers must perform CPR. Discuss with your provider the difference between DNR-CC and DNR-CC Arrest.

The Dementia Directive:

Though not legally binding in Ohio, this is a way to express your wishes for health care if you develop dementia. This directive should be completed when an individual still has the capacity needed to sign documents and make medical decisions. It should be signed in front of a notary or two adult witnesses.

Video:

Although not legally binding it's helpful to have a video of you expressing your wishes with clear language. Be sure that your proxy and loved ones have this readily accessible.

Conversations:

Normalizing conversations with loved ones and your health care proxy about your wishes for end-of-life care is the most important part of this process and helps ensure that your wishes are known and respected.

OHIO
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR OHIO ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document, a**n Ohio Advance Health Care Directive,** that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Your Ohio Advance Directive has two legal documents, the **Ohio Durable Power of Attorney for Health Care** and the **Ohio Living Will Declaration**, as well as an **Organ Donation Enrollment** form. You may complete one or both of the two legal documents, depending on your advance planning needs. You only need to complete the Donor Registry Enrollment form if you have NOT already registered as a donor with the Ohio Bureau of Motor Vehicles.

How do I make my Ohio Durable Power of Attorney for Health Care and/or Ohio Living Will Declaration legal?

You must sign and date your advance directive or direct an adult to do so for you if you are unable to sign it yourself.

Your signature must be either

- witnessed before a notary public or
- witnessed by two adult who are not:
    - Related to you,
    - Your doctor,
    - The administrator of the nursing home in which you are receiving care,
    - You agent (in the case of the Durable Power of Attorney for Health Care)

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you. Your agent cannot be:

- Your doctor;
- An administrator of a nursing home in which you are receiving care;
- An employee or agent of your doctor or your treating healthcare facility, unless he or she is related to you or is a member of your religious order (you are both monks, nuns, priests, etc.)
- A person you have a civil or criminal protective order against; or
- A person that you currently divorcing or from whom you are legally separated.

You can appoint a second and third person as your alternate agents. An alternate agent will step in if the person(s) you name as agent is/are unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Your Ohio Durable Power of Attorney for Health Care (agent) only becomes effective when your doctor determines that you have lost the capacity to make informed healthcare decisions for yourself.

Your Ohio Living will Declaration only becomes effective when your doctor determines that you have lost the capacity to make informed healthcare decisions for yourself and you are terminally ill or you are permanently unconscious. Any written instructions that you provide must be followed by your agent. You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

Your agent, if you appoint one, does not have authority to authorize removal or artificial life support unless you are determined to have a terminal condition.

Your agent will be bound by the current laws of Ohio as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your Ohio Durable Power of Attorney for Health Care and/or Living Will Declaration at any time and in any manner. Your revocation becomes effective once your doctor receives notification of you revocation. If you execute a new advance directive, it will revoke the old advance directive to the extent of any conflict between the two documents.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Your agent, if you appoint one, may make decisions about life-sustaining treatment only if you are terminally ill or permanently unconscious.

Before your agent can consent to the withholding or withdrawal of artificial nutrition and hydration on your behalf, you must check and initial the statement printed in bold letters on page 6 of the Ohio Durable Power of Attorney for Health Care.

Your agent does not have authority to refuse or withdraw care necessary to provide comfort care.

At the end of the Ohio Durable Power of Attorney for Health Care are several pages that the state of Ohio requires and that should be read before executing the document.

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

PRINT YOUR NAME AND BIRTH DATE

State of Ohio
Health Care Power of Attorney
Of

_____

(Print Full Name)

_____

(Birth Date)

This is my Health Care Power of Attorney. I revoke all prior Health Care Powers of Attorney signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

I understand that my agent can make health care decisions for me only whenever my attending physician has determined that I have lost the capacity to make informed health care decisions. However, this does not require or imply that a court must declare me incompetent.

Definitions

DEFINITIONS

Adult means a person who is 18 years of age or older.

Agent or attorney-in-fact means a competent adult who a person (the "principal") can name in a Health Care Power of Attorney to make health care decisions for the principal.

Artificially or technologically supplied nutrition or hydration means food and fluids provided through intravenous or tube feedings. [You can refuse or discontinue a feeding tube or authorize your Health Care Power of Attorney agent to refuse or discontinue artificial nutrition or hydration.]

Bond means an insurance policy issued to protect the ward's assets from theft or loss caused by the Guardian of the Estate's failure to properly perform his or her duties.

Comfort care means any measure, medical or nursing procedure, treatment or intervention, including nutrition and/or hydration, that is taken to diminish a patient's pain or discomfort, but not to postpone death.

DEFINITIONS

CPR means cardiopulmonary resuscitation, one of several ways to start a person's breathing or heartbeat once either has stopped. It does not include clearing a person's airway for a reason other than resuscitation.

Do Not Resuscitate or DNR Order means a physician's medical order that is written into a patient's record to indicate that the patient should not receive cardiopulmonary resuscitation.

Guardian means the person appointed by a court through a legal procedure to make decisions for a ward. A **Guardianship** is established by such court appointment.

Health care means any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental health.

Health care decision means giving informed consent, refusing to give informed consent, or withdrawing informed consent to health care.

Health Care Power of Attorney means a legal document that lets the principal authorize an agent to make health care decisions for the principal in most health care situations when the principal can no longer make such decisions. Also, the principal can authorize the agent to gather protected health information for and on behalf of the principal immediately or at any other time. A Health Care Power of Attorney is NOT a financial power of attorney.

The Health Care Power of Attorney document also can be used to nominate person(s) to act as guardian of the principal's person or estate. Even if a court appoints a guardian for the principal, the Health Care Power of Attorney remains in effect unless the court rules otherwise.

Life-sustaining treatment means any medical procedure, treatment, intervention or other measure that, when administered to a patient, mainly prolongs the process of dying.

Living Will Declaration means a legal document that lets a competent adult ("declarant") specify what health care the declarant wants or does not want when he or she becomes terminally ill or permanently unconscious and can no longer make his or her wishes known. It is NOT and does not replace a will, which is used to appoint an executor to manage a person's estate after death.

Permanently unconscious state means an irreversible condition in which the patient is permanently unaware of himself or herself and surroundings. At least two physicians must examine the patient and agree that the patient has totally lost higher brain function and is unable to suffer or feel pain.

Principal means a competent adult who signs a Health Care Power of Attorney.

Terminal condition means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a principal's attending physician and one other physician who has examined the principal, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

Ward means the person the court has determined to be incompetent. The ward's person, financial estate, or both, is protected by a guardian the court appoints and oversees.

DEFINITIONS

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR AGENT

Naming of My Agent. The person named below is my agent who will make health care decisions for me as authorized in this document.

Agent's Name and Relationship:

_____

Agent's Current Address:

_____

Agent's Current Telephone Number:

_____

By placing my initials, signature, check or other mark in this box, I specifically authorize my agent to obtain my protected health care information immediately and at any future time.

Guidance to Agent. My agent will make health care decisions for me based on my instructions in this document and my wishes otherwise known to my agent. If my agent believes that my wishes conflict with what is in this document, this document will take precedence. If there are no instructions and if my wishes are unclear or unknown for any particular situation, my agent will determine my best interests after considering the benefits, the burdens and the risks that might result from a given decision. If no agent is available, this document will guide decisions about my health care.

Naming of Alternate Agent(s). If my agent named above is not immediately available or is unwilling or unable to make decisions for me, then I name, in the following order of priority, the persons listed below as my alternate agents [cross out any unused lines]:

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBERS OF YOUR ALTERNATE AGENTS

First Alternate Agent: Second Alternate Agent:

Name: _____ Name: _____

Address: _____Address: _____

_____ _____

Telephone: _____ Telephone:_____

Any person can rely on a statement by any alternate agent named above that he or she is properly acting under this document and such person does not have to make any further investigation or inquiry.

Authority of Agent. Except for those items I have crossed out and subject to any choices I have made in this Health Care Power of Attorney, my agent has full and complete authority to make all health care decisions for me. This authority includes, but is not limited to, the following:

1. To consent to the administration of pain---relieving drugs or treatment or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment or procedures may hasten my death.

2. If I am in a terminal condition and I do not have a Living Will Declaration that addresses treatment for such condition, to make decisions regarding life-sustaining treatment, including artificially or technologically supplied nutrition or hydration.

3. To give, withdraw or refuse to give informed consent to any health care procedure, treatment, interventions or other measure.

4. To request, review and receive any information, verbal or written, regarding my physical or mental condition, including, but not limited to, all my medical and health care records.

5. To consent to further disclosure of information and to disclose medical and related information concerning my condition and treatment to other persons.

6. To execute for me any releases or other documents that may be required in order to obtain medical and related information.

7. To execute consents, waivers and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any person who acts while relying on this Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.

8. To select, employ and discharge health care personnel and services providing home health care and the like.

9. To select, contract for my admission to, transfer me to or authorize my discharge from any medical or health care facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.

CROSS OUT AND INITIAL ANY AUTHORITY THAT YOU DO NOT WANT YOUR AGENT TO HAVE

10. To transport me or arrange for my transportation to a place where this Health Care Power of Attorney is honored, if I am in a place where the terms of this document are not enforced.

11. To complete and sign for me the following:

CROSS OUT ANY AUTHORITY THAT YOU DO NOT WANT YOUR AGENT TO HAVE

(a) Consents to health care treatment, or to the issuing of Do Not Resuscitate (DNR) Orders or other similar orders; and

(b) Requests to be transferred to another facility, to be discharged against health care advice, or other similar requests; and

(c) Any other document desirable or necessary to implement health care decisions that my agent is authorized to make pursuant to this document.

PLACE INITIALS HERE ONLY IF YOU WANT TO AUTHORIZE YOUR AGENT TO REFUSE ARTIFICIAL NUTRITION OR HYDRATION

Special Instructions. By placing my initials, signature, check or other mark on this line, I **specifically authorize my agent to refuse or, if treatment has started, to withdraw consent to, the provision of artificially or technologically supplied nutrition or hydration** if I am in a permanently unconscious state AND my physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain: _____

GENERAL LIMITATIONS ON AGENT'S AUTHORITY

Limitations of Agent's Authority. I understand there are limitations to the authority of my agent under Ohio law:

1. My agent does not have authority to refuse or withdraw informed consent to health care necessary to provide comfort care.

2. My agent does not have the authority to refuse or withdraw informed consent to health care if I am pregnant, if the refusal or withdrawal of the health care would terminate the pregnancy, unless the pregnancy or the health care would pose a substantial risk to my life, or unless my attending physician and at least one other physician to a reasonable degree of medical certainty determines that the fetus would not be born alive.

3. My agent cannot order the withdrawal of life---sustaining treatment, including artificially or technologically supplied nutrition or hydration, unless I am in a terminal condition or in a permanently unconscious state and two physicians have determined that life---sustaining treatment would not or would no longer provide comfort to me or alleviate my pain.

4. If I previously consented to any health care, my agent cannot withdraw that treatment unless my condition has significantly changed so that the health care is significantly less beneficial to me, or unless the health care is not achieving the purpose for which I chose the health care.

Additional Instructions or Limitations.

I may give additional instructions or impose additional limitations on the authority of my agent. Below are my specific instructions or limitations:

[If the space below is not sufficient, you may attach additional pages. If you do not have any additional instructions or limitations, write "None" below.]

ADD OTHER INSTRUCTIONS OR LIMITATIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

NOMINATION OF GUARDIAN

[You may, but are not required to, use this document to nominate a guardian, should guardianship proceedings be started, for your person or your estate.]

I understand that any person I nominate is not required to accept the duties of guardianship, and that the probate court maintains jurisdiction over any guardianship.

I understand that the court will honor my nominations except for good cause shown or disqualification.

I understand that, if a **guardian of the person** is appointed for me, such guardian's duties would include making day-to-day decisions of a personal nature on my behalf, such as food, clothing, and living arrangements, but this or any subsequent Health Care Power of Attorney would remain in effect and control health care decisions for me, unless determined otherwise by the court. The court will determine limits, suspend or terminate this or any subsequent Health Care Power of Attorney, if they find that the limitation, suspension or termination is in my best interests.

I intend that the authority given to my agent in my Health Care Power of Attorney will eliminate the need for any court to appoint a guardian of my person. However, should such proceedings start, I nominate the person(s) below in the order listed as **guardian of my person.**

INITIAL THE BLANKS TO NOMINATE YOUR AGENT AS GUARDIAN OF YOUR PERSON

By writing my initials, signature, a check mark or other mark on this line, I nominate my agent and alternate agent(s), if any, to be **guardian of my person**, in the order named above.

_____

If I do not choose my agent or an alternate agent to be the **guardian of my person**, I choose the following person(s), in this order:

OTHERWISE, WRITE IN THE GUARDIAN OF YOUR PERSON HERE

Guardian of my person's name and relationship: _____

_____

Address: _____

Telephone number(s): _____

Alternate guardian of my person's name and relationship: _____

Address: _____

_____

Telephone number(s): _____

Guardian of the estate means the person appointed by a court to make financial decisions on behalf of the ward, with the court's involvement. The guardian of the estate is required to be bonded, unless bond is waived in writing or the court finds it unnecessary.

INITIAL THE BLANKS TO NOMINATE YOUR AGENT AS GUARDIAN OF YOUR ESTATE

By placing my initials, signature, check or other mark on this line, I nominate my agent or alternate agent(s), if any, as **guardian of my estate**, in the order named above.

_____

If I do not choose my agent or an alternate agent to be the **guardian of my estate**, I choose the following person(s), in this order:

OTHERWISE, WRITE IN THE GUARDIAN OF YOUR ESTATE HERE

Guardian of my estate's name and relationship: _____

_____

Address: _____

Telephone number(s): _____

Alternate guardian of my estate's name and relationship: _____

Address: _____

_____

Telephone number(s): _____

INITIAL THE BLANKS TO DIRECT THAT BOND BE WAIVED FOR THE GUARDIAN OF YOUR ESTATE

By placing my initials, signature, check or other mark in this box, I direct that bond be waived for guardian or successor **guardian of my estate**.

_____

If I do **not** make any mark on this line, it means that I expect the guardian or successor guardian of my estate to be bonded.

No Expiration Date. This Health Care Power of Attorney will have no expiration date and will not be affected by my disability or by the passage of time.

Enforcement by Agent. My agent may take for me, at my expense, any action my agent considers advisable to enforce my wishes under this document.

Release of Agent's Personal Liability. My agent will not be liable to me or any other person for any breach of duty unless such breach of duty was committed dishonestly, with an improper motive, or with reckless indifference to the purposes of this document or my best interests.

Copies the Same as Original. Any person may rely on a copy of this document.

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law.

CHECK THE APPROPRIATE BOX TO INDICATE WHETHER YOU HAVE COMPLETED A LIVING WILL

Living Will. I have completed a Living Will:

_____ Yes _____ No

Signature of Principal

I understand that I am responsible for telling members of my family and my physician, my lawyer, my religious advisor and others about this Health Care Power of Attorney. I understand I may give copies of this Health Care Power of Attorney to any person.

I understand that I may file a copy of this Health Care Power of Attorney with the probate court for safekeeping.

I understand that I must sign this Health Care Power of Attorney and state the date of my signing, and that my signing either must be witnessed by two adults who are eligible to witness my signing OR the signing must be acknowledged before a notary public.

I sign my name to this Health Care Power of Attorney

on _____, 20____, at _____, Ohio.

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

_____

Principal

[Choose Witnesses OR a Notary Acknowledgment.]

WITNESSES

The following persons CANNOT serve as a witness to this Health Care Power of Attorney:

- Your agent, if any;
- The guardian of your person or estate, if any;
- Any alternate or successor agent or guardian, if any;
- Anyone related to you by blood, marriage, or adoption (for example, your spouse and children);
- Your attending physician; and
- The administrator of any nursing home where you are receiving care.

WITNESS OR NOTARY ACKNOWLEDGEMENT

[Choose One]

Witnesses.

I attest that the principal signed or acknowledged this Health Care Power of Attorney in my presence, and that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

Witness One

Signature: _____

Print Name: _____

Address: _____

Dated: _____ , 20_____

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

Witness Two

Signature: _____

Print Name: _____

Address: _____

Dated: _____ , 20_____

OR

Notary Acknowledgment.

State of Ohio
County of _____ ss.

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

On _____, 20_____, before me, the undersigned notary

public, personally appeared _____, principal of the above Health Care Power of Attorney, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____
Notary Public

My Commission Expires: _____

THIS NOTICE IS INCLUDED IN THIS PRINTED FORM AS REQUIRED BY OHIO REVISED CODE §1337.17.

Notice to Adult Executing this Document

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the agent) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the agent to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the agent GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the agent to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the agent has general authority to make health care decisions for you under this document, the agent NEVER will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:

(a) You are suffering from an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself

(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the agent is not prohibited from doing so under (4) below, the agent could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). (YOU SHOULD UNDERSTAND THAT COMFORT CARE IS DEFINED IN OHIO LAW TO MEAN ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) WHEN ADMINISTERED TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH, AND ANY OTHER MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE THAT WOULD BE TAKEN TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH. CONSEQUENTLY, IF YOUR ATTENDING PHYSICIAN WERE TO DETERMINE THAT A PREVIOUSLY DESCRIBED MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN, THEN, SUBJECT TO (4) BELOW, YOUR AGENT WOULD BE AUTHORIZED TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE.);

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) TO YOU, UNLESS:

(A) YOU ARE IN A TERMINAL CONDITION OR IN A PERMANENTLY UNCONSCIOUS STATE.

THIS NOTICE IS INCLUDED IN THIS PRINTED FORM AS REQUIRED BY OHIO REVISED CODE §1337.17.

(B) YOUR ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED YOU DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN.

(C) IF, BUT ONLY IF, YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE, YOU AUTHORIZE THE AGENT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU BY DOING BOTH OF THE FOLLOWING IN THIS DOCUMENT:

(I) INCLUDING A STATEMENT IN CAPITAL LETTERS OR OTHER CONSPICUOUS TYPE, INCLUDING, BUT NOT LIMITED TO, A DIFFERENT FONT, BIGGER TYPE, OR BOLDFACE TYPE, THAT THE AGENT MAY REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU IF YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE AND IF THE DETERMINATION THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN IS MADE, OR CHECKING OR OTHERWISE MARKING A BOX OR LINE (IF ANY) THAT IS ADJACENT TO A SIMILAR STATEMENT ON THIS DOCUMENT;

(II) PLACING YOUR INITIALS OR SIGNATURE UNDERNEATH OR ADJACENT TO THE STATEMENT, CHECK, OR OTHER MARK PREVIOUSLY DESCRIBED.

(D) YOUR ATTENDING PHYSICIAN DETERMINES, IN GOOD FAITH, THAT YOU AUTHORIZED THE AGENT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU IF YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE BY COMPLYING WITH THE REQUIREMENTS OF (4)(C)(I) AND (II) ABOVE.

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

THIS NOTICE IS INCLUDED IN THIS PRINTED FORM AS REQUIRED BY OHIO REVISED CODE §1337.17.

Additionally, when exercising authority to make health care decisions for you, the agent will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the agent by including them in this document or by making them known to the agent in another manner.

When acting pursuant to this document, the agent GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Generally, you may designate any competent adult as the agent under this document. However, you CANNOT designate your attending physician or the administrator of any nursing home in which you are receiving care as the agent under this document. Additionally, you CANNOT designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the agent under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order. Finally, a person you designate as an agent may lose their authority to act as your agent if there is a civil or criminal protective order against them that names you as the alleged victim, or if the agent is your spouse and you are currently going through a divorce or legal separation at the time of your incapacity.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care generally will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your agent will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the agent and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicate it to your attending physician.

THIS NOTICE IS INCLUDED IN THIS PRINTED FORM AS REQUIRED BY OHIO REVISED CODE §1337.17.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The agent, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK YOUR LAWYER TO EXPLAIN IT TO YOU.

THIS NOTICE IS INCLUDED IN THIS PRINTED FORM AS REQUIRED BY OHIO REVISED CODE §1337.17.

Courtesy of CaringInfo
www.caringinfo.org, 800-658-8898

STATE OF OHIO LIVING WILL DECLARATION

Notice to Declarant

The purpose of this Living Will Declaration is to document your wish that life-sustaining treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if you are unable to make informed medical decisions and are in a terminal condition or in a permanently unconscious state. This Living Will Declaration does not affect the responsibility of health care personnel to provide comfort care to you. Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

NOTICE

If you would not choose to limit any or all forms of life-sustaining treatment, including CPR, you have the legal right to so choose and may wish to state your medical treatment preferences in writing in a different document.

Under Ohio law, a Living Will Declaration is applicable **only to individuals in a terminal condition or a permanently unconscious state**. If you wish to direct medical treatment in other circumstances, you should prepare a Health Care Power of Attorney. If you are in a terminal condition or a permanently unconscious state, this Living Will Declaration takes precedence over a Health Care Power of Attorney.

You should consider completing a new Living Will Declaration if your medical condition changes or if you later decide to complete a Health Care Power of Attorney. If you have both a Living Will Declaration and a Health Care Power of Attorney, you should keep copies of these documents together. Bring your document(s) with you whenever you are a patient in a health care facility or when you update your medical records with your physician.

State of Ohio Living Will Declaration of

PRINT YOUR NAME AND DATE OF BIRTH

_____
(Print Full Name)

_____
(Birth Date)

This is my Living Will Declaration. I revoke all prior Living Will Declarations signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

I am of sound mind and not under or subject to duress, fraud or undue influence. I am a competent adult who understands and accepts the consequences of this action. I voluntarily declare my direction that my dying not be artificially prolonged.

I intend that this Living Will Declaration will be honored by my family and physicians as the final expression of my legal right to refuse certain health care.

DEFINITIONS

Definitions

Adult means a person who is 18 years of age or older.

Agent or attorney-in-fact means a competent adult who a person (the "principal") can name in a Health Care Power of Attorney to make health care decisions for the principal.

Artificially or technologically supplied nutrition or hydration means food and fluids provided through intravenous or tube feedings. [You can refuse or discontinue a feeding tube or authorize your Health Care Power of Attorney agent to refuse or discontinue artificial nutrition or hydration.]

Comfort care means any measure, medical or nursing procedure, treatment or intervention, including nutrition and/or hydration, that is taken to diminish a patient's pain or discomfort, but not to postpone death.

CPR means cardiopulmonary resuscitation, one of several ways to start a person's breathing or heartbeat once either has stopped. It does not include clearing a person's airway for a reason other than resuscitation.

DEFINITIONS

Declarant means the person signing the Living Will Declaration.

Do Not Resuscitate or DNR Order means a physician's medical order that is written into a patient's record to indicate that the patient should not receive cardiopulmonary resuscitation.

Health care means any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical or mental health.

Health care decision means giving informed consent, refusing to give informed consent, or withdrawing informed consent to health care.

Health Care Power of Attorney means a legal document that lets the principal authorize an agent to make health care decisions for the principal in most health care situations when the principal can no longer make such decisions. Also, the principal can authorize the agent to gather protected health information for and on behalf of the principal immediately or at any other time. A Health Care Power of Attorney is NOT a financial power of attorney.

The Health Care Power of Attorney document also can be used to nominate person(s) to act as guardian of the principal's person or estate. Even if a court appoints a guardian for the principal, the Health Care Power of Attorney remains in effect unless the court rules otherwise.

Life-sustaining treatment means any medical procedure, treatment, intervention or other measure that, when administered to a patient, mainly prolongs the process of dying.

Living Will Declaration means a legal document that lets a competent adult ("declarant") specify what health care the declarant wants or does not want when he or she becomes terminally ill or permanently unconscious and can no longer make his or her wishes known. It is NOT and does not replace a will, which is used to appoint an executor to manage a person's estate after death.

DEFINITIONS

Permanently unconscious state means an irreversible condition in which the patient is permanently unaware of himself or herself and surroundings. At least two physicians must examine the patient and agree that the patient has totally lost higher brain function and is unable to suffer or feel pain.

Principal means a competent adult who signs a Health Care Power of Attorney.

Terminal condition means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a principal's attending physician and one other physician who has examined the principal, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

INSTRUCTIONS

No Expiration Date. This Living Will Declaration will have no expiration date. However, I may revoke it at any time.

Copies the Same as Original. Any person may rely on a copy of this document.

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law.

I have completed a **Health Care Power of Attorney**: Yes___ No___

Notifications. [Note: You do not need to name anyone. If no one is named, the law requires your attending physician to make a reasonable effort to notify one of the following persons in the order named: your guardian, your spouse, your adult children who are available, your parents, or a majority of your adult siblings who are available.]

In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, my physician shall make a reasonable effort to notify one of the persons named below, in the following order of priority [cross out any unused lines]:

First contact's name and relationship: _____

Address: _____

Telephone Number: _____

Second contact's name and relationship: _____

Address: _____

Telephone Number: _____

Third contact's name and relationship: _____

Address: _____

Telephone Number: _____

If I am in a **TERMINAL CONDITION** and unable to make my own health care decisions, OR if I am in a **PERMANENTLY UNCONSCIOUS STATE** and there is no reasonable possibility that I will regain the capacity to make informed decisions, then I direct my physician to let me die naturally, providing me only with **comfort care**.

For the purpose of providing comfort care, I authorize my physician to:

1. Administer no life---sustaining treatment, including CPR;
2. Withhold or withdraw artificially or technologically supplied nutrition or hydration, provided that, if I am in a permanently unconscious state, I have authorized such withholding or withdrawal under Special Instructions below and the other conditions have been met;
3. Issue a DNR Order; and
4. Take no action to postpone my death, providing me with only the care necessary to make me comfortable and to relieve pain.

Special Instructions.

By placing my initials, signature, check or other mark on this line, I specifically authorize my physician to withhold, or if treatment has commenced, to withdraw, consent to the provision of artificially or technologically supplied nutrition or hydration if I am in a permanently unconscious state AND my physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain.

_____

IF YOU WANT ARTIFICIAL NUTRITION AND HYDRATION WITHDRAWN OR WITHHELD, YOU MUST SIGN OR INITIAL HERE

ADD OTHER INSTRUCTIONS OR LIMITATIONS, IF ANY, REGARDING YOUR ANATOMICAL GIFT PLANS

ATTACH ADDITIONAL PAGES IF NEEDED

Additional instructions or limitations.
[If the space below is not sufficient, you may attach additional pages. If you do not have any additional instructions or limitations, write "None" below.]

[The "anatomical gift" language provided below is required by ORC §2133.07(C). Donate Life Ohio recommends that you indicate your authorization to be an organ, tissue or cornea donor at the Ohio Bureau of Motor Vehicles when receiving a driver license or, if you wish to place restrictions on your donation, on a Donor Registry Enrollment Form (attached) sent to the Ohio Bureau of Motor Vehicles.]

[If you use this living will to declare your authorization, indicate the organs and/or tissues you wish to donate and cross out any purposes for which you do not authorize your donation to be used. Please see the attached Donor Registry Enrollment Form for help in this regard. In all cases, let your family know your declared wishes for donation.]

ANATOMICAL GIFT (OPTIONAL)

CHECK THE APPROPRIATE BOXES IF YOU WISH TO MAKE AN ANATOMICAL GIFT

Upon my death, the following are my directions regarding donation of all or part of my body: In the hope that I may help others upon my death, I hereby give the following body parts: [Check all that apply.]

☐ All organs, tissue and eyes for any purposes authorized by law.

OR

☐ Heart	☐ Lungs	☐ Liver (and associated vessels)	☐ Pancreas/Islet Cells
☐ Small Bowel	☐ Intestines	☐ Kidneys (and associated vessels)	☐ Eyes/Corneas
☐ Heart Valves	☐ Bone	☐ Tendons	☐ Ligaments
☐ Veins	☐ Fascia	☐ Skin	☐ Nerves

For the following purposes authorized by law:

☐ All purposes ☐ Transplantation ☐ Therapy ☐ Research ☐ Education

If I do not indicate a desire to donate all or part of my body by filling in the lines above, no presumption is created about my desire to make or refuse to make an anatomical gift.

SIGN AND PRINT YOUR NAME, THE DATE, AND LOCATION HERE

SIGNATURE of DECLARANT

I understand that I am responsible for telling members of my family, the agent named in my Health Care Power of Attorney (if I have one), my physician, my lawyer, my religious advisor and others about this Living Will Declaration. I understand I may give copies of this Living Will Declaration to any person.

I understand that I must sign (or direct an individual to sign for me) this Living Will Declaration and state the date of the signing, and that the signing either must be witnessed by two adults who are eligible to witness the signing OR the signing must be acknowledged before a notary public.

I sign my name to this Living Will Declaration

on _____, 20 __, at _____, Ohio.

_____

Signature

_____

Printed Name

[Choose Witnesses OR a Notary Acknowledgment.]

WITNESSES

[The following persons CANNOT serve as a witness to this Living Will Declaration:

- Your agent in your Health Care Power of Attorney, if any;
- The guardian of your person or estate, if any;
- Any alternate agent or guardian, if any;
- Anyone related to you by blood, marriage or adoption (for example, your spouse and children);
- Your attending physician; and
- The administrator of the nursing home where you are receiving care.]

WITNESS OR NOTARY ACKNOWLEDGMENT

[Choose One]

Witnesses. I attest that the Declarant signed or acknowledged this Living Will Declaration in my presence, and that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

HAVE YOUR WITNESSES SIGN, DATE AND PRINT THEIR NAMES AND ADDRESSES HERE

Witness 1

Signature: _____

Print Name:

Address: _____

Dated: _____ , 20_____

Witness 2

Signature: _____

Print Name: _____

Address: _____

Dated: _____ , 20_____

OR

OR, if there are no witnesses,

NOTARY ACKNOWLEDGMENT

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

State of Ohio
County of _____ ss.

On _____, 20_____, before me, the undersigned Notary

Public, personally appeared _____, declarant of the above Living Will Declaration, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____
Notary Public

My Commission Expires: _____

My Commission is Permanent: _____

State of Ohio
Donor Registry Enrollment Form
Notice to Declarant

The purpose of the Donor Registry Enrollment Form is to document your wish to donate organs, tissues and/or corneas at the time of your death.

This form should be completed only if you have NOT already registered as a donor with the Ohio Bureau of Motor Vehicles (BMV) when renewing a driver license or state identification card; online through the BMV website; or previously through a paper form. If you wish to make an anatomical gift or modify an existing registration this form must be sent to the BMV to ensure your wishes for organ, tissue and/or cornea donation will be honored. This document will serve as your authorization to recover the organs, tissue and/or corneas indicated at the time of your death, if medically possible.

In submitting this form your wishes will be recorded in the Ohio Donor Registry maintained by the BMV and will be accessible only to the appropriate organ, tissue and cornea recovery agencies at the time of death. You are encouraged to share your wishes with your next of kin so they are aware of your intentions to be a donor.

This form can also be used to amend or revoke your wishes for donation. The completed form should be mailed to:

Ohio Bureau of Motor Vehicles
Attn: Records Request
P. O. Box 16583
Columbus, OH 43216-6583

Frequently asked questions about organ, tissue and cornea donation are addressed on page three of this section. If you have more specific questions, contact information for the state's organ and tissue recovery agencies is also listed, and you are encouraged to contact them or visit their websites.

If you have NOT already registered as a donor with the Ohio Bureau of Motor Vehicles (BMV) when renewing a driver license or state ID, the Ohio Donor Registry Form must be filed with the BMV to ensure your wishes concerning organ and tissue donation will be honored. This document will serve as your authorization to recover the organs and/or tissues indicated at the time of your death, if medically possible. In submitting this form, your wishes will be recorded in the Ohio Donor Registry maintained by the BMV and will be accessible only to the appropriate organ and tissue recovery agencies at the time of death. Be sure to share your wishes with loved ones so they are aware of your intentions. This form can also be used to amend or revoke your wishes for donation.

OHIO DONOR REGISTRY ENROLLMENT - PAGE 2 OF 2

TO ENROLL IN THE OHIO ORGAN DONATION REGISTRY, COMPLETE THIS FORM AND MAIL IT TO THE ADDRESS INDICATED

To register, please complete and mail this enrollment form to:
Ohio Bureau of Motor Vehicles
Attn: Records Request
P.O. BOX 16583
Columbus, OH 43216-6583

PLEASE PRINT

LAST NAME	FIRST	MIDDLE
MAILING ADDRESS		
CITY	STATE	ZIP
PHONE ( ) -	DATE OF BIRTH / /	STATE OF OHIO DL/ID CARD OR SSN

DONOR REGISTRY ENROLLMENT OPTIONS

OPTION 1

☐ Upon my death, I make an anatomical gift of my organs, tissues and eyes for any purpose authorized by law.

OPTION 2

☐ Upon my death, I make an anatomical gift of my organs, tissues and/or eyes selected below.

☐ ALL ORGANS, TISSUES AND EYES

ORGANS

☐ HEART
☐ LUNGS
☐ LIVER (AND ASSOCIATED VESSELS)
☐ KIDNEY (AND ASSOCIATED VESSELS)
☐ PANCREAS/ISLET CELLS
☐ INTESTINES
☐ SMALL BOWEL

TISSUES

☐ EYES/CORNEAS
☐ HEART VALVES
☐ BONE
☐ TENDONS
☐ LIGAMENTS
☐ VEINS
☐ FASCIA
☐ SKIN
☐ NERVES

For the Following Purposes Authorized By Law:

☐ ALL PURPOSES ☐ TRANSPLANTATION ☐ THERAPY ☐ RESEARCH ☐ EDUCATION

OPTION 3

☐ Please take me out of the Ohio Donor Registry.

SIGNATURE OF DONOR REGISTRANT	DATE
X	

Courtesy of CaringInfo
www.caringinfo.org

end of life WASHINGTON
Your life. Your death. Your choice.

ALZHEIMER'S DISEASE/DEMENTIA MENTAL HEALTH ADVANCE DIRECTIVE OF:

_____

(Print your name here.)

As a person with capacity, I willfully and voluntarily execute this mental health advance directive, so that my choices regarding my mental health care and Alzheimer's/dementia care will be carried out in circumstances when I am unable to express my instructions and preferences regarding my future care. If I live in a state that has not adopted laws that provide me with the legal right to make this advance directive, then I want this document to be used as a guide for those who make decisions on my behalf when I am no longer capable of making them for myself.

The fact that I may have left blanks in this directive does not affect its validity in any way. I intend that all completed sections be followed.

I understand that nothing in this directive, including any refusal of treatment that I consent to, authorizes any health care provider, professional person, health care facility, or agent appointed in this directive to use or threaten to use abuse, neglect, financial exploitation, or abandonment to carry out my directive.

I intend this Alzheimer's Disease/Dementia Mental Health Directive to take precedence over any other mental health directives I have previously executed, to the extent that they are inconsistent with this Alzheimer's Disease/Dementia Mental Health Advance Directive.

I understand that there are some circumstances where my provider may not have to follow my directive, specifically if compliance would be in violation of the law or accepted standards of care.

1. WHEN AND HOW LONG I WANT THIS DOCUMENT TO APPLY

(*Initial only one – a., b., or c. – and draw a line through the others*)

a. _____ I intend that this directive become effective **immediately** upon signing and that it remains valid and in effect until revoked according to the terms specified in section 16 or until my death.

b. _____ I intend that this directive become effective if I become incapacitated to the extent that I am unable to make informed consent decisions or provide informed consent for my care, as determined by my treating medical provider, and that it remain valid and in effect until revoked according to the terms specified in section 16 or until my death.

c. _____ I intend that this directive become effective when any of the following circumstances, symptoms, or behaviors occur, and that it remain valid and in effect until revoked according to the terms specified in section 16 or until my death: *(Initial all that apply, and draw a line through the rest.)*

(1) _____ I am no longer able to communicate verbally.

(2) _____ I can no longer feed myself.

(3) _____ I can no longer recognize my partner/spouse.

(4) _____ I put myself or my family or others in danger because of my actions or behaviors.

(5) _____ Other *(describe)*:_____

2. WHEN I MAY REVOKE THIS DIRECTIVE

I intend that I be able to revoke this directive: *(Initial one, and draw a line through the other.)*

_____ Only when I have capacity: I understand that choosing this option means I may only revoke this directive if I have capacity. I further understand that if I choose this option and become incapacitated while this directive is in effect, I mayreceive treatment that I specify in this directive, even if I object at the time.

_____ Even if I am incapacitated: I understand that choosing this option means that I may revoke this directive even if I am incapacitated. I further understand that if I choose this option and revoke this directive while I am incapacitated I may not receive treatment that I specify in this directive, even if I want the treatment.

3. MY MENTAL HEALTH CARE AGENT

I appoint the following person as my primary mental health care agent to make mental health care treatment decisions for me as authorized in this document and request that this person be notified immediately when this directive becomes effective: *(Optional, but highly recommended.)*

Name _____

Address _____

Telephone _____

(day) (evening) (mobile)

If the person named above is my partner or spouse at the time I make this document: {Initial one and put a line through the other. If your primary mental health care agent is not your spouse or partner, cross this section out.}

_____ His or her authority to act is hereby revoked if I am separated or divorced from her or him.

_____ His or her authority to act shall be unaffected if I am separated or divorced from her or him.

In the event that my primary mental health care agent is unable, unavailable, or unwilling to serve, or I revoke his or her authority to serve, then I name this alternate mental health care agent and request that this person be notified immediately when this directive becomes effective or when the primary mental health care agent is no longer my agent: *(Optional, but highly recommended.)*

Name _____

Address _____

Telephone _____

(day) (evening) (mobile)

If my alternate mental health care agent acts for me because my first agent is unavailable, I intend that the alternate act only while my first agent is unavailable.

4. THE AUTHORITY I GIVE MY MENTAL HEALTH CARE AGENT

I grant my mental health care agent complete authority to make all decisions about mental health care on my behalf. This includes, but is not limited to (a) consenting, refusing consent, and withdrawing consent for mental health treatment recommended by my medical providers; (b) requesting particular mental health treatments consistent with any instructions and/or limitations I have set forth in this directive; (c) accessing my medical records and information pertaining to my mental health care; (d) employing and dismissing mental health care providers; and (e) removing me from any mental health care facility to another facility, a private home, or other place. I authorize and request that all “covered entities” under the Health Insurance Portability and Accounting Act of 1996, as hereafter amended, release and disclose full and complete protected medical information to my health care agent named herein. Such information should include, but not be limited to, medical records, office notes, laboratory results, radiology and other visualization records, prescription records,

medical opinions, and all other materials that might assist in medical decision-making or a determination of my capacity. I understand that this information may include information about sexually transmitted diseases, AIDS, HIV, and the use/abuse of alcohol and drugs. This consent is subject to revocation at any time except to the extent that the entity which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this authorization will terminate upon my death.

The authority conferred herein shall be exercisable notwithstanding my disability or incapacity.

5. HOW TO MAKE MENTAL HEALTH CARE DECISIONS AND IMPLEMENT THIS DIRECTIVE

I want whoever makes mental health care decisions for me to do as I would want in the circumstances, based on the choices I express in this document. If what I would want is not known, then I want decisions to be made in my best interest, based on my values, the contents of this document, and information provided by my health care providers.

I do not want my mental health care agent or others to substitute their choices for mine because they disagree with my choices or because they think their choices are in my best interests. I do not want my intentions to be rejected because someone thinks that if I had more information when I completed this document, or if I had known certain medical facts that developed later, I would change my mind.

6. PERSONAL HISTORY AND CARE VALUES STATEMENT

(Optional. If you attach a statement, initial this. If not, draw a line through it.)

_____ I have completed and attached an additional statement describing why I am making this metal health advance directive and/or to provide information about the important people in my life, some personal history, general values around care, or anything else that is not addressed by this document.

7. PREFERENCES AND INSTRUCTIONS ABOUT MY CARE AND TREATMENT

a. Preferences regarding care in my home.

(1) **I prefer that my personal care and assistance be provided by:** *(Number the choices below, using the number 1 for your first choice, 2 for your second choice, etc. Draw a line through those that do not apply.)*

_____ Family members who would do so voluntarily.

_____ Individuals who are not family members who would do so voluntarily.

_____ Family members who are hired to provide my care.

_____ Individuals who are not family members who are hired to provide my care.

_____ Other *(describe)*:

(2) **I have the following cultural, religious, and/or gender preferences about my care and assistance:**
(Optional. If you do not have any preferences, draw a line through this space.)

b. Preferences and instructions involving out-of-home placements.

I recognize that I may need to receive care outside of my home – even in my least desirable setting (a nursing home or other placement) – when my care at home becomes too burdensome or difficult to manage. This may be necessary if I become combative, aggressive, incontinent, resistant to care, or too difficult to transfer. If my mental health care agent decides that I need to live in a setting outside of my home, then the following are my preferred locations and settings, in order of preference:

(1) **The location where I would prefer to live:** *(Number the choices below, using the number 1 for your first choice, 2 for your second choice, etc. Draw a line through those that do not apply.)*

_____ With/near the following family member or other loved one near my current home:
_____

_____ With/near the following family member or other loved one far away from my current home:
_____

_____ Near my current home.

_____ Other *(describe)*:

(2) **The setting where I would prefer to live:** *(Number the choices below, using the number 1 for your first choice, 2 for your second choice, etc. Draw a line through those that do not apply.)*

_____ Adult family home. Name: *(optional)*_____

_____ Assisted living facility. Name: *(optional)* _____

_____ Nursing home. Name: *(optional)*_____

_____ Specialized memory care unit. Name: *(optional)* _____

_____ Moving in with family. Name: *(optional)* _____

_____ Other *(describe)*:

(3) **If an assessment and/or recommendations about my ability to remain in my home become necessary, the following person/people or agency/agencies is preferred:** *(Optional. If you do not have a preference, draw a line through this space.)*

c. Preferences and instructions about dealing with combative, assaultive, or aggressive behaviors, with authority to consent to inpatient treatment. *(Initial all that apply, and draw a line through those that do not.)*

(1) I recognize that sometimes people with Alzheimer's/dementia become aggressive, assaultive, or combative, despite good care. If this happens, and emergency or other treatment is necessary: *(Initial one or the other directly below; i.e., give your consent or do not consent. If neither is initialed, or you do not consent to voluntary admission to inpatient treatment, commitment could still occur without consideration of the provisions in the "I consent…" statement.)*

_____ I consent and authorize my mental health care agent to consent to voluntary admission to inpatient treatment for up to 14 days, if deemed appropriate by my agent and treating medical provider. I prefer to receive treatment in a facility specializing in Alzheimer's/dementia care to work on the reduction of my behavioral symptoms and stabilization of my condition.

_____ I do not consent to voluntary admission to inpatient treatment.

(2) _____ I want treatment from trained caregivers who know me and my history, and who know how to handle the situation.

(3) _____ My preference is to be admitted to the specialized geriatric or dementia care unit at

_____
or a similar facility, if available.

(4) ____ My preference is **not** to be admitted to the following facility or facilities:
(Optional. If you do not have a preference, draw a line through this space.)

d. Preferences regarding the financing of my care.

I know that the cost of my care could become high over the course of my illness. I have the following preferences regarding the financing of my care: *(Initial all that apply. Draw a line through those that do not.)*

_____ My hope is that my care costs will not consume the lifetime of savings I have reserved for retirement and for my children or other heirs at my death.

_____ I want my partner/spouse to maintain the standard of living we now have as much as possible.

_____ I want to preserve as much as possible of my income, assets, and savings for my partner/spouse, children, and heirs. Please use all available planning options to meet this goal, including, but not limited to: *(Cross out any that you do not agree with or that are not applicable.)*

(1) Medicaid planning.
(2) Gifting.
(3) Divorce or legal separation.
(4) Changing estate planning documents.
(5) Tax planning.

_____ Please use my income, assets, and savings to buy the highest quality private care for me.

_____ If my savings run out, I want my home to be sold to finance any further care I need.

_____ I prefer public assistance only if no other option exists for paying for my care.

e. Preferences regarding future intimate relationships.

(1) **Continuation of my intimate relationships with my partner/spouse:** *(Initial all that apply. Draw a line through those that do not. Cross out this entire section if it is not applicable.)*

_____ My intimate relationship with my partner/spouse,

*(name here)*_____, is important to both of us.

_____ I consent to maintaining our sexual relationship even in the event that we dissolve our partnership or legal domestic partnership or divorce.

_____ We want to maintain our sexual relationship for as long as possible.

_____ I know that I may forget my partner/spouse as my Alzheimer's/dementia progresses. Even if this happens, I want to continue to be intimate for as long as my partner/spouse wants to and feels comfortable doing so.

_____ If I need nursing home care, I request the privacy needed for us to continue our relationship, as required by law.

_____ I completely trust my partner/spouse to make any judgments about the continuation of our intimate relationship, including when to stop if s/he is no longer comfortable.

_____ Other preference(s):

(2) **Preferences regarding my partner/spouse having relationships outside the bounds of our partnership/marriage or other commitment, legally recognized or otherwise:** *(Initial all that apply. Draw a line through those that do not. Cross out this entire section if it is not applicable.)*

_____ I understand that my illness may last a long time, and that I likely will no longer recognize or be able to function emotionally or sexually for my partner/spouse. I also care deeply that my partner/spouse not continue to be a victim of this disease and that s/he live her/his life to the fullest. This could include becoming involved in other relationships. I would not consider this a violation of our vows to each other. Rather, I hope that s/he does seek out companionship and intimacy when I can no longer provide that in the relationship.

_____ Our moral, religious, and/or ethical values dictate that we remain faithful to one another through sickness and in health. We have both discussed this, and believe that a relationship outside our partnership/marriage or other committed relationship is not permissible and should not be pursued.

_____ I completely trust my partner/spouse to make any judgments about having relationships outside the bounds of our partnership/marriage, or other committed relationship.

_____ Other preference(s):

(3) **Preference regarding future intimate relationships for myself:** *(Initial all that apply. Draw a line through those that do not.)*

_____ I know that residents at long-term care facilities sometimes develop relationships with each other that can result in a less depressing and/or happier time for both. I am not completely opposed to my having such a relationship if, in my mental health care agent's judgment, I seem happier and am not coerced in any way.

_____ My moral, religious, and/or ethical beliefs preclude my engagement in any other relationship besides my partnership/marriage, or other committed relationship, whether legal or otherwise. I do not consent to any other intimate relationships, even if I appear to be happier at the time.

_____ Other preference(s):

f. **Preferences regarding my pet(s).** *(If you have a pet or pets, write your preferences here. If not, draw a line through this space.)*

8. CONSENT TO PARTICIPATION IN EXPERIMENTAL ALZHEIMER'S/DEMENTIA DRUG TRIALS

(If you initial a, b, or c, or any combination of a, b, or c, you must draw a line through d. If you initial d, you must draw a line through a, b, and c. Draw a line through any that you do not initial.)

a. _____ I consent to participation in any clinical drug trials for drugs that have the potential to ameliorate the symptoms of Alzheimer's/dementia or prevent the full onset of the disease. I not only hope to improve my own health, but also to contribute to research to find a cure for the disease. I give my mental health care agent full power to consent on my behalf to my participation in any such study, considering my preferences regarding side effects.

b. _____ I do not want to take medications that have the following side effects or have the following treatments: {optional}

c. _____ If my memory loss can be slowed down by the experimental drug(s), I am willing to participate in the trial even if it could lead to my earlier death. I would rather die sooner but with my memory more intact.

d. _____ I do not consent to participation in any drug trials.

9. CONSENT REGARDING SUSPENSION OF MY DRIVING PRIVILEGES

(Initial only one, and draw a line through the other.)

_____ My ability to drive is a very important part of my maintenance of independence. I enjoy driving and want to continue to do so as long as I am safe. On the other hand, I know that the time will come when I no longer have the ability to drive safely. I trust the skilled health care professional(s) who are providing my treatment. *(Name of health care professional(s) here; optional. If you do not want to name someone, put lines through these spaces.)*

_____

_____

_____.

If s/he is not available, I want any other skilled health care professional to test my visual and mental acuity to determine if I am no longer safe to drive.

_____ I trust my mental health care agent's judgment on this issue. If my mental health care agent determines that I am unfit to drive, I consent to my driving privileges being suspended. If I continue to drive or attempt to drive after this, I agree to my keys being hidden or taken away from me and/or access to my car being eliminated.

10. REGARDING A HEALTH CARE INSTITUTION REFUSING TO HONOR MY WISHES

(Initial all that reflect your views. Draw a line through any that do not.)

_____ I understand that circumstances beyond my control may cause me to be admitted to a health care or long-term care facility whose policy is to decline to follow advance directives that conflict with certain religious or other beliefs or organizational policies. If I am a patient in such a health care institution or long-term care facility when this Alzheimer's/Dementia Mental Health Advance Directive takes effect, I direct that my consent to admission shall not constitute implied consent to procedures, policies, or courses of treatment mandated by religious or other policies of the institution or facility, if those procedures, policies, or courses of treatment conflict with this mental health advance directive.

_____ If the health care or long-term care facility in which I am a patient declines to follow my wishes as set out in this mental health advance directive, I direct that I be transferred, if possible, in a timely manner to another institution or facility which will agree to honor the instructions set forth in this mental health advance directive.

11. IF A COURT APPOINTS A GUARDIAN FOR ME

If a guardian is appointed by a court to make mental health decisions for me, I intend this document to take precedence over all other means of ascertaining my intent and preferences. The appointment of a guardian of my estate or my person or any other decision-maker shall not give that guardian or decision-maker the power to revoke, suspend, or terminate this Directive or the powers of my mental health care agent, except as authorized by law.

In the event the court appoints a guardian who will make decisions regarding my mental health treatment, I nominate the following person as my guardian:

Name _____

Address _____

Telephone _____

(day) (evening) (mobile)

12. OTHER DOCUMENTS

In planning for my health care, estate, and potential incapacity, I have executed the following documents: *(Initial and provide information for all that apply. Draw a line through those that do not.)*

_____ **General Power of Attorney:** *(Name and contact info of primary agent.)*

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

_____ **Durable Power of Attorney for Finances:** *(Name and contact info of primary agent.)*

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

_____ **Durable Power of Attorney for Health Care:** *(Name and contact info of primary health care agent.)*

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

_____ **Living Will/Health Care Directive/Directive to Physicians:** *(Name and contact info of person who has a copy.)*

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

_____ **Portable Orders for Life-Sustaining Treatment (POLST):**
(Optional; name and contact information of person who has access to your POLST.)

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

_____ **Other Document:** *(Optional; name here:_____.)*

Name _____

Address _____

Telephone _____
(day) (evening) (mobile)

13. SUMMARY AND SIGNATURE

I understand what this document means. I make this document of my free will, and I believe I have the mental and emotional capacity to do so.

By signing here, I indicate that I understand the purpose and effect of this document, and that I am giving my informed consent to the treatments and/or admission that I have consented to, or that I have authorized my agent to consent to, in this directive. I intend that my consent in this directive be construed as being consistent with the elements of informed consent under RCW chapter 7.70 in the State of Washington or applicable law in other states.

_____ _____

Signature of person making this document. Date

(Sign only in the presence of two witnesses.)

14. STATEMENT OF WITNESSES

This directive was signed and declared by

(Print your name – not the names of your witnesses – on the following line.)

_____ to be her/his directive. It was signed in our presence at her/his request. We declare that at the time of the creation of this directive

(Print your name – not the names of your witnesses – on the following line.)

_____ is personally known to us and, according to our best knowledge and belief, has capacity at this time and does not appear to be acting under duress, undue influence, or fraud. We further declare that none of us is:

a. A person designated to make medical decisions on the principal's behalf.
b. A health care provider or professional person directly involved with the provision of care to the principal at the time the directive is executed.
c. An owner, operator, employee, or relative of an owner or operator of a health care facility or long-term care facility in which the principal is a patient or resident.
d. A person who is related by blood, marriage, legal domestic partnership, or adoption to the person, or with whom the person making this document has a dating relationship as defined in RCW 26.50.010 in the State of Washington or applicable law in other states.
e. An incapacitated person.
f. A person who would benefit financially if the principal undergoes mental health treatment.
g. A minor.

WITNESS 1

_____ _____

Signature Date

_____ _____

Printed Name Phone

_____

Address

WITNESS 2

_____ _____

Signature Date

_____ _____

Printed Name Phone

_____

Address

15. RECORD OF DIRECTIVE

I have given a copy of this directive to the following persons:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

IMPORTANT: DO NOT FILL OUT THIS PAGE UNLESS YOU INTEND TO REVOKE THIS DIRECTIVE IN PART OR IN WHOLE.

16. REVOCATION OF MY ALZHEIMER'S DISEASE/DEMENTIA MENTAL HEALTH ADVANCE DIRECTIVE

(Initial either 1 or 2, and draw a line through the one you did not initial. If you initial 1, then list the sections that you are revoking by number. For example: "Sections 2, 6, and 7.")

_____ 1. I am revoking the following part(s) of this directive (specify):

_____

_____

_____

_____

_____ 2. I am revoking this entire directive.

By signing here, I indicate that I understand the purpose and effect of my revocation and that no person is bound by any revoked provision(s). I intend this revocation to be interpreted as if I had never completed the revoked provision(s).

_____ _____

Signature of person who made this document Date

DNR ORDER FORM

A printed copy of this order form or other authorized DNR identification must accompany the patient during transports and transfers between facilities.

Patient Name:	Patient Birth Date:
Optional Patient or Authorized Representatives Signature	
Printed name of Physician, APRN or PA*	Date
REQUIRED Signature of Physician, APRN or PA	Phone
REQUIRED for APRN or PA: Name of the supervising physician (PA) or collaborating physician (APRN) for this patient and the physician's NPI, DEA or Ohio medical license number.	

CHECK ONLY ONE BOX BELOW

☐ **DNR Comfort Care — Arrest:** Providers will treat patient as any other without a DNR order until the point of cardiac or respiratory arrest at which point all interventions will cease and the DNR Comfort Care protocol will be implemented.

☐ **DNR Comfort Care:** The following DNR protocol is effective immediately.

DNR PROTOCOL

Providers Will:

- Conduct an initial assessment
- Perform Basic Medical Care
- Clear airway of obstruction or suction
- If necessary for comfort or to relieve distress, may administer oxygen, CPAP or BiPAP
- If necessary, may obtain IV access for hydration or pain medication to relieve discomfort, but not to prolong death
- If possible, may contact other appropriate health care providers (hospice, home health, physician, APRN or PA)

Providers Will Not:

- Perform CPR
- Administer resuscitation medications with the intent of restarting the heart or breathing
- Insert an airway adjunct
- De-fibrillate, cardiovert or initiate pacing
- Initiate continuous cardiac monitoring

Physicians, emergency medical services personnel, and persons acting under the direction of or with the authorization of a physician, APRN or PA who participate in the withholding or withdrawal of CPR from the person possessing the DNR identification are provided **immunities under section 2133.22 of the Revised Code.** This DNR order is effective until revoked and may not be altered. Any medical orders, instructions or information other than those required elements of the form itself, that are written on this order form are not transportable and are not provided protections or immunities.

* A DNR may be issued by an Advanced Practice Registered Nurse (APRN) or Physician Assistant (PA) when authorized by section 2133.211 of the Ohio Revised Code.

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