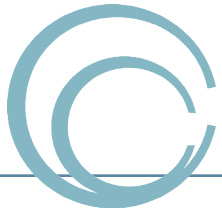

compassion & choices
Care and Choice at the End of Life.

Advance Directive

Planning for Important Healthcare Decisions

Colorado

SECTION (1)
INTRODUCTION TO YOUR COLORADO ADVANCE DIRECTIVES FOR HEALTHCARE

Every adult needs Advance Directives for healthcare. Regardless of age, regardless of health, none of us knows when a future event might leave us unable to speak for ourselves. If you become unable to make or communicate decisions about your medical treatment, a written record of your healthcare wishes would prove invaluable.

WHAT ARE ADVANCE DIRECTIVES FOR HEALTHCARE?

“Advance Directives” are a generic term used for documents that traditionally include a Living Will (a Colorado Declaration as to Medical or Surgical Treatment), a Medical Durable Power of Attorney (MDPOA), Cardiopulmonary Resuscitation (CPR) Directives and Medical Orders for Scope of Treatment (MOST).

The “Living Will” portion of an Advance Directive is a place for you to specify what kinds of treatment and care you would or would not want if you were unable to speak for yourself. This document allows you to provide instructions relating to your future healthcare, such as when you wish to receive medical treatment or when you wish to stop or refuse life-sustaining medical treatments. The Medical Durable Power of Attorney allows you to appoint someone (an “Agent”) to act on your behalf in matters concerning your healthcare when you are unable to speak for yourself due to illness or incapacitation. CPR Directives and MOST will be described in detail later.

WHY ARE THEY USEFUL?

Advance Directives help you to maintain control over healthcare decisions that are important to you when you are unable to make or communicate decisions due to any temporary or permanent injury or illness. They allow you to express your wishes about any aspect of your healthcare, including decisions about life-sustaining treatment. They also allow you to choose a person to speak on your behalf and communicate your decisions when you are not able to do so. Appointing an agent and making sure your agent is aware of and understands your wishes is one of the most important things you can do. If the time comes for a decision to be made, your agent can participate in relevant discussions, weighing the pros and cons of treatment decisions based on your wishes. Your agent can make healthcare decisions on your behalf whenever you cannot do so for yourself, even if your decision-making capacity is only temporarily affected. Another important consideration is your family**:** Advance Directives help relieve the stress and duress associated with having to make important healthcare decisions on behalf of someone they care about. By making your wishes known in advance, you help your

family and friends know what you would want done. Otherwise they may struggle to decide on their own.

ARE ADVANCE DIRECTIVES FOR HEALTHCARE LEGALLY VALID IN EVERY STATE?

Yes, Advance Directives are legally valid in every state. Each state (and the District of Columbia) has laws that permit individuals to sign documents stating their wishes about healthcare decisions when they cannot speak for themselves. The specifics of these laws vary, but the basic principle of listening to the patient's wishes is the same everywhere. The law gives great weight to any form of written directive. If the courts become involved, they usually try to follow the patient's stated values and preferences, especially if they are in written form. An Advance Directive for healthcare may be the most convincing evidence of your wishes you can create. It is important to note that while it is legal to have an Advance Directive in every state, no current law requires that they be strictly honored by healthcare professionals. Most states have reciprocity in their statutes regarding medical durable power of attorney.

HOW DO I MAKE ADVANCE DIRECTIVES FOR HEALTHCARE?

You do not need a lawyer to complete your Advance Directives. However, a lawyer may be helpful if your family situation is complex or if you expect problems to arise. If you wish, you can start by making a copy of the MDPOA and Living Will beginning on page 7. If there are portions of this document with which you disagree, it is legally acceptable for you to cross them out and write your initials in the margin.

The next step would be to share and discuss your Advance Directives with your agent(s) as well as other trusted friends or relatives.

Your primary healthcare providers are also important participants to include in the creation of your Advance Directive. Based on your medical history and your current health, discuss the types of medical problems you may face. Your provider can help you to better understand potential treatment options. Make sure your provider clearly understands your treatment wishes and goals.

Compassion & Choices provides up-to-date state-specific information about Advance Directives. Take the time to consider what is important to you and seek advice so that your Advance Directive reflects your beliefs. If you would like help completing your Advance Directive for healthcare, call Compassion & Choices at 1-800-247-7421.

Colorado law requires that you sign your Living Will in the presence of two witnesses. These witnesses must also sign your Living Will. In Colorado, your MDPOA does not have to be signed, but some other states require signatures. We have thus combined the Living Will with the MDPOA so that you need only one set of signatures for both

documents. Your witnesses must be at least 18 years old and cannot be any of the following**:** entitled to any portion of your estate under your last will and testament or by operation of law, your attending healthcare professional or any other treating healthcare professional, or an employee of your attending healthcare professional or treating healthcare facility. At this time, it is not required to have these documents notarized in Colorado. However, notarization will assist in interstate reciprocity, as well as emphasizing the legality of the documents.

IF I CHANGE MY MIND, CAN I CHANGE OR CANCEL MY ADVANCE DIRECTIVE FOR HEALTHCARE?

Yes, you can change or cancel your Advance Directives at any time. You can do this by notifying your agent and/or healthcare provider in writing of your decision to do so. It is best to destroy all copies of your old Advance Directive and create a new one. Make sure to provide copies of your new form to the appropriate individuals. Compassion & Choices recommends that you periodically review your Advance Directives and re-sign and date them to indicate that this documents continues to reflect your wishes.

WHO SHOULD BE MY AGENT?

One of the most important things you can do is to appoint an agent to speak for you if and when you are ever unable to do so for yourself. An agent has great power over your healthcare and should be carefully chosen. In normal circumstances, no one will be monitoring your agent and his/her decisions. To help avoid disagreements, we recommend selecting one primary agent and at least one alternate agent. Your alternate agent would speak on your behalf if your primary agent were unwilling or unable to speak for you. Your agent must agree to serve in this role. It might be important to specify that your healthcare agent bears no financial burden or liability if he/she agrees. Agents must be 18 or older, and have decisional capacity. If the agent is a spouse and the couple later divorces, legally separates or annuls the marriage, the agent is automatically removed unless otherwise expressly stated in the document. Before deciding on an agent (and alternatives), ask yourself**:** “Are they assertive? Will they be able to make difficult and possibly emotional decisions? Do they live nearby? Are they comfortable talking about death? Will they respect my values and wishes?” Then, talk to them. Share your wishes and make sure they clearly understand what is important to you. Go over the medical-directive section of your Living Will with them. Confirm their willingness to speak on your behalf. Take into consideration that your children or your parents may not necessarily be the best choices to be your agents. It is often very emotionally difficult for intimate relatives to allow their close ones to die, even though they intellectually may agree with your Living Will.

In Colorado, because we have no default surrogate decision-makers, it really is essential to appoint an agent. In addition to family, think about friends, colleagues, clergy, or

professional advisors. If you cannot think of anyone, contact Compassion & Choices at 1-800-247-7421 for help in locating an agent.

If you do not appoint an agent, and your healthcare provider (or a court) determines that you lack decisional capacity, then a proxy for healthcare will be appointed. In order to accomplish this, a search will be conducted to locate an "interested party" such as a family member, friend, or advisor. Again, if you cannot think of anyone to appoint, contact Compassion & Choices at 1-800-247-7421 for help in locating an agent.

HOW CAN I MAKE SURE HEALTHCARE PROVIDERS WILL FOLLOW MY ADVANCE DIRECTIVES?

Currently, there are no state laws that oblige medical personnel to honor your Advance Directives. Some healthcare providers have values and opinions that do not agree with the wishes you have expressed on either ethical or medical grounds. Because of this, they may not want to follow the directions you have provided. Colorado law allows doctors or healthcare facilities to refuse to honor your Advance Directive on conscience grounds. However, they must help you find another healthcare professional, or facility, willing to honor your wishes. While this is rare, it is important to be aware of its potential. To help avoid this situation, talk to your healthcare providers ahead of time. Make sure they understand your wishes and are familiar with your Advance Directive documents. And make sure they are willing to honor them. If they object, work out the issues or find another healthcare provider.

Once your Advance Directives are completed and signed, provide a copy to your agent, all healthcare providers, close friends and relatives, and anyone else who may be involved with your care.

DEVELOPING YOUR OWN PHILOSOPHY ABOUT LIVING AND DYING:

Because death is a part of every life, there are several reasons for giving thought to death before having to face the near approach of it. One reason is that you will handle it better if it is on your own terms as much as possible. Another is that it will be very helpful to those who care about you if they know definitely what your preferences are. Here are some questions about life as well as death, which may be helpful in thinking things through.

- Have you accepted the fact that you are going to die one day?
- Is it death or the process of dying that is of most concern?
- Have you thought about decisions and consequences of a terminal condition if that occurs?
- Have you had a friend or relative whose dying was a prolonged process, who lingered on long after he or she wanted only the release of death?

- Are you able to savor the small things in daily life, things that you perhaps used to take for granted?
- What are some of the things in life that bring you warm satisfaction to recall?
- Have you given thought to the meaning of life? If yes, do you consider a meaning in general, or the specific meaning of your own life at any given moment?
- Do you think it is important to establish a meaning of life?
- What would you think if at some point you felt that your life had lost all meaning? Examples: the death of someone dear to you, a terminal illness, when you have no control over your life, or feel that you have become "useless."
- Does death, then, have a connection with the meaningfulness of life?
- Does this quotation make sense to you? Do you want to amend it in some way? *Is there not a certain satisfaction in the fact that natural limits are set to the life of the individual, so that at its conclusion it may appear as a work of art?* - Albert Einstein

If you had a terminal illness, at what point would you want the release of death?

- Intractable symptoms: pain, nausea, fatigue, anorexia, anxiety, confusion, incontinence, difficulty swallowing or breathing, sleeplessness or sleepiness
- Unacceptable indignities such as helplessness and loss of bowel and bladder control, inability to wash, dress, eat, walk, transfer to a toilet or commode
- Dementia: loss of self / memory / communications capacity / radical personality changes such as repeated angry outbursts for no reason
- Unwillingness to prolong the anguish of those you love as they watch you deteriorate and linger to no purpose
- Unwillingness to see your life savings go to the dying industry rather than to those you love or to causes you believe in
- Simple inability to enjoy living any longer under the given conditions of life and health

You may rate what is important to you by marking each blank with either 1, 2, 3, 4, or 5, “1” being the least important and “5” being the most.

_____Wanting to know the truth about my condition.
_____Wanting to take part in decision-making involving my healthcare.
_____Wanting my healthcare agent to participate in my healthcare decision-making if I am unable to decide for myself.
_____Letting nature “take its course."
_____Maintaining my quality of life.
_____Maintaining my dignity.
_____Maintaining my privacy.
_____Living as long as possible, regardless of quality of life.

_____Having physical mobility.
_____Having good eyesight.
_____Having good hearing.
_____Having reasonable mental capacity.
_____Being able to speak.
_____Being able to communicate with others nonverbally —writing, touching, blinking.
_____Having independence and control in my life.
_____Avoiding being a burden on others.
_____Being comfortable and pain-free, even if it may hasten my death.
_____Leaving good memories for friends and family.
_____Leaving assets for family, friends, charities, etc.
_____Dying in a short while, as opposed to a lingering process.
_____Managing financial aspects.

Other thoughts and feelings regarding medical treatments:
_____
_____
_____
_____
_____
_____
_____

_____ _____
Signature Date

SECTION (2)
ADVANCE DIRECTIVES

2(a) MEDICAL DURABLE POWER OF ATTORNEY

By this document, I intend to create a Medical Durable Power of Attorney, provide an Advance Directive for treatment when I am in a terminal state, and make a Declaration as to Medical or Surgical Treatment (a Living Will). Third parties may rely on the representations of my Agent who is designated to serve my interest.

I, (name) _____,
of (city and state) _____, the Principal, hereby appoint (name of Agent, with city and state)
_____,
to serve as my Agent and to exercise the powers set forth below. If my Agent ceases to act due to inability or unwillingness to continue to serve, I hereby designate (name of first substitute Agent, with city and state) _____ as my first substitute Agent. If my substitute ceases to act due to inability or unwillingness to continue to serve, I designate (name of second substitute Agent, with city and state) _____.

ACTIVE DATE AND DURABILITY:

By this document I intend to create a Medical Durable Power of Attorney effective upon, and only during, any period of disability or incapacity in which, in the opinion of my attending healthcare professional, I am unable to make or communicate responsible decisions regarding medical treatment or healthcare for myself.

AGENT POWERS:

I grant to my Agent full authority to make decisions for me regarding my medical and psychological treatment and healthcare. In exercising this authority, my Agent shall follow my desires as stated in my Declaration as to Medical or Surgical treatment. In making decisions, my Agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my Agent cannot determine the choice I would want made, then my Agent shall make a choice for me based upon what my Agent believes to be in my best interests. My Agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below. Accordingly, my Agent is authorized as follows:
(a) To consent, refuse, or withdraw consent to any and all types of psychiatric and medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect bodily function, including (but not

limited to) artificial respiration, artificial nourishment and hydration, and cardiopulmonary resuscitation;
(b) To have access to my medical records and information to the same extent that I am entitled, including the right to disclose the contents to others;
(c) To authorize my admission to or discharge from (even against medical advice) any hospital, nursing home, residential care, assisted living, or similar care facility or service;
(d) To contract on my behalf for any healthcare-related service or facility, without my Agent's incurring personal financial liability for such contracts;
(e) To retain and discharge medical, social service and other support personnel responsible for my care;
(f) To authorize any medication or procedure intended to relieve pain for me, even though such use may lead to physical damage or addiction, or may hasten the moment of (but not intentionally cause) my death;
(g) To make anatomical gifts as follows. *(Initial those that apply)*
_____ I authorize my agent to make anatomical gifts on my behalf for the limited purpose of transplantation, which shall take effect upon my death, to such persons and organizations as my agent shall deem appropriate, and to execute such papers and do such acts as shall be necessary, appropriate, incidental, or convenient with such gifts.
_____ I authorize my agent to make tissue gifts only on my behalf for the limited purpose of transplantation, which shall take effect upon my death, to such persons and organizations as my agent shall deem appropriate, and to execute such papers and do such acts as shall be necessary, appropriate, incidental, or convenient with such gifts.
_____ I authorize my agent to make anatomical gifts on my behalf for the purposes of medical research, and to execute such papers and do such acts as shall be necessary, appropriate, incidental, or convenient in connection with such gifts.
_____I do not authorize my agent to make any anatomical gifts on my behalf following my death.
(h) To take any other action necessary to implement my preference as to my healthcare as expressed herein or elsewhere, including (but not limited to) granting any waiver or release from liability required by any hospital, healthcare professional, or other healthcare provider; signing any documents relating to a refusal of treatment or the discharge from a facility against medical advice; and pursuing any legal action in my name and at my or my estate’s expense to force compliance with my wishes as determined by my Agent, including claims for actual or punitive damages for any such failure to comply.

ACCESS TO MY MEDICAL RECORDS AND OTHER PERSONAL INFORMATION:

My Agent shall have the power to request, receive, review and release any information, including drug-and-alcohol treatment information, mental health information, medical and hospital records and other data having special protections under the law, specifically including the Health Insurance Portability and Authorization Act of 1996 (HIPAA), regarding my physical or mental health; and to execute any releases, waivers, insurance forms, or other documents that may be requested in order to obtain such

information; or to obtain government assistance or insurance payment for any service rendered to me or for my benefit. Each person nominated to be my Agent shall specifically be authorized to receive all personal health information and documents necessary to determine my incapacity as if such person were already acting as my Agent.

GRANTING RELEASES:

My Agent, on behalf of me, my heirs, and my estate, shall have the power to grant waivers or releases from liability to healthcare providers and other persons or covered entities (as defined under HIPAA) involved in providing healthcare services for me or maintaining my protected health information and other healthcare records who act in reliance on instructions given by my Agent for the purpose of carrying out the provisions of this document.

RELEASE OF INFORMATION:

I hereby authorize all “covered entities” as defined under the Health Insurance Portability and Authorization Act of 1996 (HIPAA) (including healthcare professionals and all other providers of healthcare services, mental healthcare, drug and alcohol treatment, hospitals, residential care facilities, insurance providers and medical-information processors) to release to my Agent, or to my Agent’s designee, all individually identifiable protected health information or photocopies of any records which my Agent may request in order to carry out my Agent’s responsibilities hereunder. I hereby waive all privileges which may be applicable to such information and records and to any communication pertaining to my health and made in the course of any confidential relationship recognized by the law, specifically including the Health Insurance Portability and Authorization Act of 1996 (HIPAA). I understand that any protected health information released to my Agent or nominee is not protected from further disclosure, as my Agent deems necessary or advisable. This release shall terminate upon revocation of this Power of Attorney.

SIGNATURES: As previously stated, signatures for the combined MDPOA and the Living Will are at the end of Section 2(b) below.

2(b) LIVING WILL AND DECLARATION AS TO MEDICAL / SURGICAL TREATMENT

(a) If I should either: 1) have an terminal injury, illness or disease; 2) be in a prolonged, and/or irreversible comatose or persistent vegetative state; or 3) be in an advanced stage of progressive dementia in which I am unable to coherently communicate, swallow food and water safely, care for myself, and recognize my family and other people, and if two healthcare professionals* certify in writing that there is no reasonable probability of recovery from these conditions, then I direct that such procedures listed below, where I have written and initialed "yes," be withheld or withdrawn and that I be permitted to die naturally. Such life-sustaining procedures include, but are not limited to, the following:

_____(1) Surgery, unless it is absolutely necessary to control pain
_____(2) Antibiotics (using drugs to fight infection), when they will not significantly improve my comfort
_____(3) Cardiopulmonary resuscitation including electronic shock in the event of cardiac arrest
_____(4) Invasive diagnostic tests
_____(5) Intubation (insertion of a tube to admit air or administer gases)
_____(6) Respirator support (breathing by machine)
_____(7) Blood or blood products (such as transfusions)
_____(8) Kidney dialysis
_____(9) Heart-regulating drugs, including electrolyte replacement, if my heartbeat becomes irregular
_____(10) Cortisone or other steroid therapy, if tissue swelling threatens vital centers in my brain
_____(11) Stimulants, diuretics or any other treatment for heart failure, if the strength and function of my heart is impaired
_____(12) The withholding of administration of pneumonia vaccine
_____(13) Artificial hydration and nutrition (giving food and fluid through a tube in the veins, nose or stomach), except as my healthcare professional determines to be necessary to provide comfort only, but not to maintain life.
_____(14) Eating and drinking by mouth

(b) It being understood that life-sustaining procedures shall not include any medical procedure or intervention for nourishment considered necessary by the attending physician to provide comfort or alleviate pain, I direct that, in accordance with Colorado law and pursuant to the terms of this declaration, life-sustaining procedures shall be (initial only the option that applies):

_____ withdrawn; or
_____ withheld; or
_____ continued for a period of not less than _____ days, and if there be no change in my condition which would indicate to my healthcare professional that my prognosis

has improved, then I direct that life-sustaining procedures shall be withdrawn and/or withheld; or
_____ continued indefinitely, regardless of my condition or prognosis

* Please note that “healthcare professional" is a current term used in medical documents to reflect that, in some rural areas, there is no healthcare professional available and either a licensed physician's assistant or nurse practitioner is the only attending health provider.

I am aware that withholding or withdrawing any of these procedures may hasten my death, but I consider it against my interests and the interests of my survivors to have my body artificially maintained after the possibilities of reasonable physical and/or mental recovery is gone (initial yes ___ or no_____).

(c) Such person as I appoint with this Medical Durable Power of Attorney for healthcare, after consultation with my healthcare professional, may use such person's best judgment to distinguish between treatments that are humane and those that only postpone the moment of death.
(d) Specifically in regard to NOURISHMENT AND HYDRATION, I have checked and initialed the following items I agree with:

_____(1) If I am incompetent but conscious, and unable or unwilling to eat or to be fed in the usual manner, I declare my wish to voluntarily stop eating and drinking by mouth and to refuse tube feeding through my nose and/or throat and/or through any surgical insertion of a tube, or through intravenous feeding except insofar as is necessary to provide comfort only, but not to maintain life, as determined by my physician and approved by my Agent.

_____(2) If I am unconscious and the procedure being administered to me is tube or intravenous feeding, once my physician and physician consultant have established that there is not a reasonable likelihood that I will ever return to a conscious state with the ability to be oriented and to interact in a reasonably unimpaired way with my environment (such as the condition sometimes called the Permanent or Persistent Vegetative State), I declare my wish to have such artificial feeding withheld or withdrawn. I am aware that this may hasten my death, but I consider it against my interests and the interests of my survivors to have my body artificially maintained after reasonable hope of mental recovery is gone.

EXCULPATION:

(a) My Agent and my Agent’s estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, heirs, successors, and assigns from all liability and from all claims or demands of all kinds arising out of the acts or missions

of my Agent. No person who relies in good faith upon any representations by my Agent or Successor Agent shall be liable to me, my estate, my heirs or my successors or assigns for recognizing the Agent's authority.
(b) Any healthcare professional, nurse, or other individual acting on my behalf is authorized and directed to follow these instructions. No healthcare professional signing a certificate of terminal condition and no healthcare professional, hospital or hospital personnel withholding or withdrawing life-sustaining procedures in compliance with this declaration, in the absence of actual knowledge of revocation or fraud, misrepresentation, or improper execution, shall be subject to civil liability, criminal penalty, or licensing sanctions therefor. On behalf of myself, my Agent, my family and my heirs and devisees, I hereby release any person who acts in reliance on the foregoing sentence from any claim or liability for any injury to me or arising by reason of my death.

NOMINATION OF GUARDIAN:

If a guardian of my person should for any reason be appointed, I nominate my Agent (or successor) named above.

ADMINISTRATIVE PROVISIONS:

(a) I revoke all prior powers of attorney or Advance Directives for healthcare.
(b) This Medical Durable Power of Attorney and Living Will is intended to be valid in any jurisdiction in which it is presented.
(c) The powers delegated under these documents are separable, so that the invalidity of one or more powers shall not affect any others.
(d) Photocopies of these documents shall be as effective as the original. I specifically direct my Agent to have photocopies of these documents placed in my medical records.
(e) This document shall be governed by the laws of the State of Colorado in all respects, including its validity, construction, interpretation, and termination. I intend for these documents to be honored in any jurisdiction where it may be presented and for any such jurisdiction to refer to Colorado law to interpret and determine the validity of these documents and any of the powers granted under these documents.

REVOCATION AND RESIGNATION:

I reserve the right to revoke or amend these documents and to substitute other agents in place of those designated herein. Amendments or revocation shall be made in writing by me personally, not by any agent of mine, and shall be attached to the original of these documents. My agent and any alternate agent may resign by the execution of a written resignation delivered to me or, if I am mentally incapacitated, by delivery to any person in charge of my care and custody.

SEVERABLITY:

If any part of any provision of this document shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity only, without in any way affecting the remaining provisions of this document.

RESOLUTION WITH THESE DOCUMENTS AND MY AGENT'S WISHES:

I have executed this Directive for Medical / Surgical Treatment (Living Will) declaring my wishes regarding the continued use of life-sustaining procedures or artificial nutrition and hydration in the event I am in a terminal condition or persistent vegetative state and I am unable to make medical decisions for myself. I have also named my agent in this Medical Durable Power of Attorney. In the event that the decisions of my agent shall conflict with this Directive: *(Initial One)*
____My preferences in this Directive shall prevail over the wishes of my agent.
____My agent under this Directive shall have authority to override my preferences as stated in this Directive.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THESE DOCUMENTS AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT. I AM OF SOUND MIND AND WILLFULLY AND VOLUNTARILY EXECUTE THIS DOCUMENT. I sign my name to this Medical Durable Power of Attorney and Directive for Medical / Surgical Treatment on this _____ day of _____, 20_____.

Signature of Principal _____
Principal's home address: _____.

Witnesses are named below, along with the Acceptance of Appointment.

2(c) WITNESSES' STATEMENT

I do hereby declare that the Principal (the person who has signed or acknowledged this document), _____, has signed or acknowledged this Medical Durable Power of Attorney Document in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence. To the best of my knowledge, I am not a creditor of the Principal nor entitled to any part of his or her estate under a will now existing or by operation of law.

Witness No. 1
Signature: _____ Date: _____
Print Name: _____ Phone(s): _____
Address: _____

Witness No. 2
Signature: _____Date: _____
Print Name: _____ Phone(s): _____
Address: _____

2(d) AGENTS' ACCEPTANCE OF APPOINTMENT

The undersigned accept appointment as Agent(s) under this Medical Durable Power of Attorney.

Print Name of Agent: _____ Home Phone: _____
Signature: _____Other Phone: _____
Address: _____

Print Name of 1st Substitute Agent: _____Home Phone:_____
Signature: _____Other Phone: _____
Address: _____

You may have a second Substitute Agent should you wish:

Print Name of 2nd Substitute Agent _____ Home Phone: _____
Signature: _____ Other Phone: _____
Address: _____

Notarization is optional. If you wish to have this Living Will notarized, use the following form:

STATE OF COLORADO
CITY _____ COUNTY _____

Subscribed and sworn to before me by _____,
the Principal, and _____ and
_____and _____, as witnesses,
as the voluntary act and deed of the Principal, this _____ day of_____, 20___.

Notary Public _____
Address of Notary Public: _____
My commission expires _____

2(e) MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST)

The Medical Orders for Scope of Treatment (MOST) document for Colorado is now a legally binding document. In some other states, it is sometimes referred to as Physician Orders for Life-Sustaining Treatment (POLST). In general, this form is intended for use by those with serious, chronic, or terminal illness and/or who are in treatment facilities. It is a one-page, two-sided form that summarizes a person's wishes regarding specific treatment and scope of treatment. It does not replace your Living Will, but rather, when signed by a physician, physician's assistant, or nurse practitioner, serves as a medical order which must be accepted and followed in any healthcare facility in the state. The form may be downloaded by going to Google and typing "MOST Form for Colorado" into the "search" box. Copies, faxes, or scans of the MOST are just as valid as the original.

2(f) DIRECTIVE TO WITHHOLD CARDIOPULMONARY RESUSCITATION

If your heart or breathing should malfunction or stop, emergency medical service personnel must, by law, attempt cardiopulmonary resuscitation (CPR); your consent is assumed. Fewer than 10% of elderly persons will survive a resuscitation procedure. If they do recover, he or she often sustains broken ribs and irreversible brain damage. If you wish to refuse CPR, you will need to execute a Notice of Patient or Authorized Agent's Directive to Withhold Cardiopulmonary Resuscitation (or "CPR Directive"). A template form may be downloaded from the Colorado Department of Health and Environment Web site (http://1.usa.gov/16 HVHz8), or you can use the form provided here. This form must have a physician's signature, as well as your or your Agent's, but other forms (such as the MOST) are acceptable as CPR directives as well. In fact, any clear, written statement refusing CPR which is "apparent and immediately available" to responding emergency personnel should be honored. To be extra certain that it will be honored, using the template form is strongly advised.

"No CPR" bracelets or necklaces may be purchased from Awards and Signs, Ltd, 6801 S. Dayton, Greenwood Village, CO 80112, 303-799-8979 for $27.95 (2013 price). Orders must include both a check and a photocopy or fax of the signed CPR Directive.

COLORADO DIRECTIVE FOR WITHHOLDING CPR
NOTICE OF PATIENT OR AUTHORIZED AGENT'S DIRECTIVE
TO WITHHOLD CARDIOPULMONARY RESUSCITATION (CPR)

Patient's name: _____
Name of authorized agent, proxy, guardian/parent(s) of minor child (if this should be applicable): _____
Patient's Date of Birth: ___/_____/____ Gender**:** Male Female Eye Color: _____
Hair Color: _____ Race/Ethnicity: _____Asian or Pacific Islander _____Black, Non-Hispanic _____White, non-Hispanic ___American Indian or Alaska Native ___Hispanic ___Other
Name of Hospice Program (if applicable):_____
Attending Healthcare Professional:

_____
Attending Healthcare Professional's Address

_____
Attending Healthcare Professional's Phone ( ) _____ License # _____
Directive made on this date: _____, pursuant to Colorado Revised Statute 15-18.6-101.

Check only one of the following (as appropriate):
___ Patient: I am over the age of 18 years, of sound mind and acting voluntarily. It is my desire to initiate this directive on my behalf, and I have been advised that the expected result of executing this directive is my death, in the event that my heart or breathing stops or malfunctions.
___ Authorized agent/proxy/legally authorized guardian/parent(s) of minor child: I am over the age of 18 years, of sound mind, and I am legally authorized to act on behalf of the patient named above in the issuance of this directive. I have been advised that the expected result of executing this directive is the death of the patient, in the event the patient's heart or breathing stops or malfunctions.
I hereby direct emergency medical services personnel, healthcare providers, and any other person to withhold cardiopulmonary resuscitation in the event that my/the patient's heart or breathing stops or malfunctions. I understand that this directive does not apply to other medical interventions for comfort care. If I/the patient am/is admitted to a healthcare facility, this directive shall be implemented as a healthcare professional's order, pending further healthcare professionals' orders. *Use of original signatures on each page of this form makes each page an original document.*

Signature_____
(Signature of **:** __Patient or __ authorized agent/proxy/legally authorized guardian/parent(s) of minor child)

_____
Signature of Attending Healthcare Professional

Consent to the following tissue donation is optional. These tissue donations do not require resuscitation:

I hereby make an anatomical gift, to be effective upon my death, of:

___ Any needed tissues, or the following tissues:
___skin
___cornea
___bone
___related tissues and tendons.

Donor/Agent Signature: _____

Again, this page is included for informational purposes only.

(3) MY LAST WISHES**
An Addendum to My Advance Directives

I, as a person of clear and sound mind and under no coercion, endorse the items **INITIALED** on this directive. I do so with the understanding that there is a chance that none of these eventualities will befall me or that they all might. My wishes stated here have been carefully considered.
___ They have been discussed with persons whom I have appointed as my healthcare agents.
___ My agents agree with my wishes.
___ This addendum is a supplement to and does nothing to negate my Advance Directives and my Medical Durable Power of Attorney but is appended to ensure that my additional wishes will be known by all who may care for me. This cannot cover all possibilities, but it particularly applies to irreversible brain conditions where there is a strong likelihood that cogitative function cannot be restored, where I cannot speak for myself and where there is no life support to disconnect so that death could occur easily.
___ I wish to die with dignity and in peace. It is important for me to know that I will not have to die a lingering and/or demeaning death or endure a hopeless and severely disabling condition which would involve great suffering for myself and/or those I love. I would like to choose when and how I die and to seek help in carrying out that decision.
___ To further indicate that this is an enduring request, I have been a member of the Hemlock Society, which is now called Compassion & Choices, since _____.
___ It should be clear that despite my wish to choose death, I want the best possible medical care, including life-sustaining measures when the prognosis appears to be favorable and if there is a reasonable chance that I will be restored to independent living that has meaning and offers enjoyment, with my pre-crisis level of cognition intact.

TO THOSE WHO CARE ABOUT ME:

___ If I am ill and homebound or in a hospital or nursing home, I would ask those persons who are close to me not to abandon me but to visit as much as I or they can tolerate, and to insure that I have adequate care and that my wishes are carried out.
___ I ask that you respect my view of dying and death and not try to impose your philosophy or beliefs on me, no matter how well-meaning. Quality of life and autonomous decision-making are high priorities for me.

STATEMENT OF DESIRES:

_____I want all the provisions of my Advance Directives to be implemented.
_____My preference would be to die (circle one)**:** at home with (or without) hospice care**;** in a hospital; other (specify)_____.
_____I desire (circle one): cremation, burial, donation to medical facility (specify) _____

_____I would like (circle one)**:** memorial service; funeral; neither;
other_____.

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT. I AM OF SOUND MIND AND WILLFULLY AND VOLUNTARILY EXECUTE THIS DOCUMENT.

Signature _____
Date _____, 20 ____

** My Last Wishes is not officially a legal document, but rather a statement of personal desires.

(4) CONSENT FOR RELEASE OF MEDICAL RECORDS

A. Patient requesting release of Medical Records: _____

B. Medical Records requested from all those who hold such medical records, including but not limited to:
_____and any other person in the medical field who holds my records

C. Who is to receive the Medical Records:
_____

I, the patient ("A" above) hereby authorize the holder(s) ("B" above) of my confidential medical records and information named above to share and discuss any and all medical, mental health, social work, legal, or other treatment and confidential information concerning me, and to provide copies of same to the persons named in (C) above. I or my estate will cover the costs incurred.

Signature_____ Date _____

PURPOSES AND EFFECTS OF THIS CONSENT:

I have asked the advocacy program of Compassion & Choices of Colorado—and specifically those named in "C" above—to intervene regarding my care, treatment, and support in the event I cannot speak for myself.

This Consent will assist my patient advocate(s) to communicate with the holders of my confidential medical records regarding my needs for consenting to or refusing health-care. I intend for any agent serving hereunder to be treated as my “personal represent-tative” as defined in 45 CFR 164.502(g) of the Health Insurance Portability and Account-ability Act of 1996 (“HIPAA”), so as to have all authority and rights that I would person-ally have with respect to the use and disclosure of my individually identifiable protected health information or other medical records.

I recognize that information disclosed by a covered entity pursuant to this authorization is subject to further disclosure and may no longer be protected by the HIPAA privacy rules.

This release shall expire one year after my death unless earlier revoked in writing.
Effective Date: This Consent is effective from the date of signature.

_____ _____
Patient Signature Date

Notarization is optional. You may use this form if you wish:

STATE OF COLORADO
CITY _____ COUNTY _____

Subscribed and sworn to before me by
_____, the Principal,
as the voluntary act and deed of the Principal, this _____ day of _____, 20_____.

Notary Public_____

Address of Notary Public _____

My commission expires: _____

(5) MEDICAL INFORMATION FORM

Patient's Name _____
Date_____
Date of Birth _____ Phone(s) _____
Address _____
City _____State _____ Zip _____

Below are the names and phone numbers of the advocacy persons I have designated to be my agents if I am unable to make or oversee the execution of healthcare decisions for myself.

Advocate's Name _____ Phone(s) _____
Address _____

Alternate _____ Phone(s) _____
Address_____

Provide your Advance Directives with this form. If your lawyer has a copy, give his/her name and phone number (below). Give a copy of this form to your attorney.

Doctor's name and phone
_____
Other doctor's name and phone _____
Have you discussed your wishes with your doctor(s)? _____
With your family? _____
With anyone else? _____
Name _____
Name _____
Are there people who may disagree with your wishes? If so, who?
Name _____
Name _____
What might these persons do?
_____
Are there any other concerns?
_____
_____
_____
Contact information for attorney, if any _____

(6) QUESTIONS TO ASK YOUR HEALTHCARE PROVIDER

It is important for you and your Healthcare Provider (HCP) to understand each other. The following list of questions should provide both of you with the information necessary for such an understanding. If your HCP intimidates you or belittles your questions, consider finding a more sympathetic HCP. To facilitate the session between you and your HCP, bring the following with you**:**

1) This list of questions
2) A list of your vitamins, herbs, supplements, prescription and nonprescription drugs and their dosages
3) A list of your vital statistics, such as allergies, other conditions, surgeries
4) A friend or family member
5) Copies of your Advance Directives, Last Wishes and other pertinent documents above.

Make sure your HCP is aware that your documents include HIPAA authorization to release your records to your agents and other necessary persons.

Questions regarding tests:

1) What tests will be performed for diagnosis?
2) What are the risks and reliability of these tests?
3) How long will it take to get results?
4) Will I need to take time off from work for these tests?

Questions regarding your condition

1) What is the diagnosis?
2) Are there alternate diagnoses?
3) What is the prognosis?
4) How long will I need this treatment?
5) *If the treatment is unsuccessful, will you accept the terms of my Advance Directives?*

Questions regarding medication

1) How will the medication help my condition?
2) What are the side effects of this treatment?
3) How long will I need to take the medication?
4) Will this medication interfere with other medications I am taking?

Questions before surgery

1) What are the goals of surgery?
2) What are the alternatives to surgery?
3) What is the surgical procedure?
4) What are the choices of anesthesia?
5) What are the risks of surgery?
6) How long will it take to recover from surgery?
7) If treatment is unsuccessful and there is NO hope of recovery, would you explore with me and my agent options on dying? If my condition is hopeless, would you be willing to help me to die? If family members disagree, would you continue to be my advocate?

(8) IMPORTANT THINGS TO DO AND REMEMBER

1) Do **NOT** put the originals of your signed, witnessed, and notarized Advance Directives and other important documents in a safe-deposit box or any place that would keep others from having access to them. Tell your agent and family where these vitally important papers can readily be found. (Again, in Colorado, at this time, notarization is recommended but not required.)
2. The "Last Wishes," although not strictly a legal document, should be attached as an addendum to the other documents.
3. Give photocopies of the signed originals to your agent and to your substitute agents, doctors, family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home, hospital or long-term residential-care facility, have photocopies made and placed in your medical records.
4. Be sure to talk to your agent, substitute agent (sometimes referred to as "the alternate"), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes often, especially if your medical condition changes.
5. If you want to make any changes to your documents after they have been signed and witnessed, you should complete **new** documents, and gather in and destroy former documents.
6. Remember, you can always revoke one or more of your Colorado documents.
7. Should death occur at home, the county coroner or your doctor should be called, as a qualified medical professional needs to be notified to make the official pronouncement of death. If hospice is being used, they will also help with this notification. ***If the patient does not have a NO CPR Directive or is not wearing the bracelet or necklace, caretakers need to be aware that the paramedics will try to resuscitate. If the patient and family have been expecting death and do not want CPR administered, do not call 911.***
8. The initial choice of a funeral home to remove the body is a crucial decision made at the time of death, as it can have serious financial impact. A family member or close friend should accompany the bereaved next of kin to the mortuary to advise and support that individual in making arrangements for the service. (This information is provided by Funeral Consumer Society of Colorado, 303-759-6431.)
9. If **direct cremation** is planned, the crematory may be able to collect the body directly. If you wish to make an **anatomical gift**, please call 303-724-2410.
10. Family and close friends also need to be notified and asked to help the next of kin with the notification of other family, friends, close neighbors, the church, and the organizations the deceased was a member of, and help with other immediate tasks.
11. It is important that the crucial papers and information regarding prepaid funeral policies and instructions for a service, etc., are kept where the family members can find them easily. If the deceased was receiving public assistance or was a member of the military, financial assistance may be available to help cover funeral expenses. Social Services should be notified regarding anyone receiving public assistance, and the V.A. should be contacted regarding anyone who is currently or was previously in the military.

12. It is important that someone be responsible for answering the phone, collecting mail, caring for pets, keeping track of gifts of food or flowers and noting who the donors are; and for finding someone to stay in the home during the service and having refreshments available if a reception is to be held in the home following the service.

We hope this information has been helpful to you. If you have questions you can contact either Compassion & Choices of Colorado or the national Compassion & Choices office. Contact information is below.

Compassion & Choices of Colorado
PO Box 101824
Denver, CO 80250
303-639-1202
compassionandchoicesofcolorado.org

National Compassion & Choices
PO Box 101810
Denver, CO 80250
1-800-247-7421
info@compassionandchoices.org