SGCMH
Ste. Genevieve County
Memorial Hospital

Patient Name:_____

Date of Birth:_____

Advance Directive Declaration and Durable Power of Attorney for Health Care

NOTE: This document may have significant legal consequences. Although review by an attorney is not required, it is highly encouraged.

I make this HEALTH CARE DIRECTIVE to exercise my right to determine the course of my health care and to provide clear and convincing proof of my wishes and instructions about my treatment.

If I am persistently unconscious and/or there is no reasonable expectation of my recovery from a seriously incapacitating or terminal illness or condition, the life-prolonging procedures listed below should (yes) or should not (no) be done according to my preference marked below:

I. Advance Directive

If you do not wish to make a Health Care Directive, write you're initial on this line _____ and go to Part II on back.

Read each statement below and indicate your preference by checking the box and signing your initials next to it.

Yes	No	Initial	
___	___	_____	1. Artificially supplied food and/or water (tube feeding, I.V., etc.)
___	___	_____	2. Heart-Lung resuscitation (CPR)
___	___	_____	3. Antibiotics (bacteria fighting drugs)
___	___	_____	4. Mechanical ventilator (respirator or artificial lung)
___	___	_____	5. Dialysis (kidney filtering machine)
___	___	_____	6. Chemotherapy (medicine treating cancer)
___	___	_____	7. Radiation therapy (radiation treating cancer)
___	___	_____	8. Surgery or other invasive procedure (s).

I direct I be given medicine to relieve pain even if such treatment might shorten my life, suppress my appetite, or, form habits.

However, if my physician believes that any life-prolonging procedure may lead to significant recovery, I direct my physician to try the treatment for a reasonable period of time. If it does not improve my condition, I direct the treatment be withdrawn even if it shortens my life. I also direct that I be given medical treatment to relieve pain or to provide comfort, even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming. You may define reasonable significant recovery and reasonable period of time here: _____

Other instructions are as follows: _____

_____

If you have not designated an agent in the Durable Power of Attorney this document is meant to be in full force and effects as my Health Care Directive.

You must sign this document in the presence of two witnesses.

In witness whereof, I have executed this document this _____ day of _____ , _____

Signature _____

Witness _____ Witness _____

This person who signed this document appears to be of sound mind and voluntarily signed this document in our presence. Each of the undersigned witnesses are at least 18 years of age.

I hereby revoke the above declaration. Date: _____

Signature of Declarant: _____

ADV DIR

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II. Durable Power Of Attorney For Health Care

If you do not want to name a Durable Power of Attorney for Health Care, write your initials on this line _____

I hereby appoint the following person as my Durable Power of Attorney for Health Care to act for me and in my name to make health care decisions in the event I am unable to do so, in accord with the directions I have made, including, but not limited to the power to: consent, refuse consent, or withdraw consent to any care, treatment, procedure or device, even if my death may result; inclusive of moving me into or out of any health care facility, access medical records, or to make gifts of all or part of my body for medical research or education.

This Durable Power of Attorney and the authority of the person so appointed to exercise all powers above shall become effective if and when TWO physicians decide and certify that I am incapacitated and unable to make and communicate a health care decision, shall remain in full force and effect during my incapacity and be revoked if and when I regain capacity to decide for myself.

1) Selection of Agent

Name _____ Phone _____

Address _____

2) Alternate Agent

If that person named above resigns or is not able or available to make health care decisions for me, then I appoint the following person named below as an alternate to have the same powers.

Name _____ Phone _____

Address _____

Signature _____ Date _____

In witness whereof, I have executed this document this _____day of _____, _____

Notary Public

(Notarization only required for durable power of Attorney for Health Care)

State of _____ County of _____

On this _____ day of_____, _____

Personally appeared before me who executed the foregoing instrument and acknowledge that he or she executed the same as his or her free act and deed. In testimony whereof, I have hereunto set my hand and affixed my official seat in the county and state aforementioned on the day and year first written.

Commission Expiration Date _____

Notary Signature _____

ADV DIR