

ADVANCE DIRECTIVE

A LIVING WILL

A Directive To Withhold Or
To Provide Treatment

and

A Durable Power Of Attorney FOR HEALTH CARE

Name

Date of Birth

LIVING WILL AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Idaho Medical Consent and Natural Death Act Idaho Code Title 39, Chapter 45 Effective July 1, 2007

Date of Directive: _____

Name of Person Executing Directive: _____

Address of Person Executing Directive: _____

A LIVING WILL

A Directive to Provide or to Withhold Treatment

1. I willfully and voluntarily make known my desires related to medical care at the end of life, specifically the option of artificially prolonging my life under the circumstances listed below.

This Directive is only effective if I am unable to communicate my instructions and:

- a. I have an incurable or irreversible injury, disease, illness or condition and one (1) medical doctor has examined me and certified:
 1. That my injury, disease, illness, or condition is terminal; and
 2. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and
 3. That my death is imminent, whether or not life-sustaining procedures are utilized,

Or

- b. I have been diagnosed as being in a persistent vegetative state.

In such event, I direct that the following marked expression of my intent be followed and that I be permitted to die naturally, and that I receive any medical treatment or care that may be required to keep me free of pain or distress.

CHECK ONLY ONE OPTION AND INITIAL NEXT TO THE BOX

Option 1. All Treatment, Artificial Nutrition and Hydration

____ If at any time I should become unable to communicate my instructions, then I direct that all medical treatment, care, and procedures necessary to restore my health and sustain my life, be provided to me. Nutrition and hydration, whether artificial or nonartificial **shall not be withheld or withdrawn from me** if I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition.

OR

Option 2. Artificial Nutrition and/or Hydration

____ If at any time I should become unable to communicate my instructions and where the application of artificial life-sustaining procedures shall serve only to prolong artificially my life, I direct that all medical treatment, care and procedures including artificial life-sustaining procedures be withheld or withdrawn **except that I direct that nutrition and hydration, whether artificial or nonartificial shall be provided to me as directed below.**

Nutrition and hydration (whether artificial or non artificial) shall be provided to me if, by withholding or withdrawing nutrition and hydration, I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness, or condition.

Check one box and initial. If none of the following boxes are checked and initialed, then both nutrition and hydration, of any nature, whether artificial or nonartificial, will be administered:

- ____ Only hydration of any nature, whether artificial or non artificial shall be administered;
- ____ Only nutrition of any nature, whether artificial or non artificial shall be administered;
- ____ Both nutrition and hydration of any nature, whether artificial or nonartificial shall be administered.

OR

Option 3. Comfort Care

____ If at any time I should become unable to communicate my instructions and where the application of artificial life-sustaining procedures shall serve only to prolong artificially the moment of my death, **I direct all medical treatment, care and procedures be withheld or withdrawn including withdrawal of artificial nutrition and hydration.**

I direct nutrition and hydration be offered for as long as I desire and am able to take liquids, ice chips and/or food by mouth. I specifically direct that I not receive food by gastric or nasogastric tube or in any way other than by mouth, and that I not receive fluids in anyway other than by mouth.

If because of disability, stroke, accident, or other cause, I should become incompetent and unable to make decisions concerning my medical care, I direct my family and physicians not to use artificial means, including but not limited to tube and intravenous (or other artificial) feeding, to prolong my life unless, based on the then current medical knowledge, there is a medically reasonable expectation of a substantial recovery of my mental and physical functions. I specifically request that under such circumstances, I not be resuscitated and that I not receive any electric shock treatments, blood transfusions, mechanical ventilators, cardiopulmonary resuscitation, dialysis or other invasive technologies. I also direct the withholding of treatment of reversible secondary conditions when an irreversible primary condition meets the standard set forth in this directive. **I do, however, direct medical treatment or care that may be required to keep me free of pain or distress be provided.**

[Definitions of artificial life-sustaining procedure; artificial nutrition and hydration; and health care decision in Appendix.]

2. If I have been diagnosed as pregnant, this Directive shall have no force during the course of my pregnancy.
3. I understand the full importance of this directive and am emotionally and mentally competent to make this directive. No participant in the making of this directive or in its being carried into effect, whether it be a medical doctor, my spouse, a relative, friend or

any other person shall be held responsible in any way, legally, professionally or socially, for complying with my directions.

CHECK ONLY ONE OPTION AND INITIAL NEXT TO THE BOX

4. _____ I have discussed these decisions with my physician and have also completed a Physician Orders for Scope of Treatment (POST) which contains directions that may be more specific than, but are compatible with, this Directive. I hereby approve of those orders and incorporate them here as completed.

OR

_____ I have not completed a Physician Orders for Scope of Treatment (POST). If a POST is later signed by my physician, then this living will shall be deemed modified to be compatible with the terms of the POST.

A DURABLE POWER OF ATTORNEY FOR HEALTH CARE

1. DESIGNATION OF HEALTH CARE AGENT. *None of the following may be designated as your agent: (1) your treating health care provider; (2) a nonrelative employee of your treating health care provider; (3) an operator of a community care facility; or (4) a nonrelative employee of an operator of a community care facility. If the agent or an alternate agent designated in this Directive is your spouse, and your marriage is dissolved, the designation shall be thereupon revoked.*

I do hereby designate and appoint the following individual as my attorney in fact (agent) to make health care decisions for me as authorized in this Directive. (Insert name, address, and telephone number of one individual only as your agent to make health care decisions for you.)

Health Care Agent

Name: _____

Address: _____

Telephone Number: _____

[For the purposes of this Directive, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose or treat an individual's physical condition.]

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE. By this portion of this Directive, I intend to create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity. This power shall be effective only when I am unable to communicate rationally.

3. GENERAL STATEMENT OF AUTHORITY GRANTED. I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this Directive or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing artificial life-sustaining care, treatment, services, and procedures, including such desires set forth in a living will, POST or similar document executed by me, if any.

[If you want to limit the authority of your agent to make health care decisions for you, state the limitations in paragraph four (4) "Statement of Desires, Special Provisions, and Limitations" below. You can indicate your desires by including a statement of your desires in the same paragraph.]

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. *Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning:*

- a. Artificial life-sustaining care, treatment, services, and procedures, and*
- b. Other matters relating to your health care, including a list of one or more persons whom you designate to be able to receive medical information about you and/or to be allowed to visit you in a medical institution.*

You can also make your desires known to your agent by discussing your desires with your healthcare agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this Directive, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.

In exercising the authority under this durable power of attorney for health care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated in my "Physician Orders for Scope of Treatment (POST)", a living will or similar document executed by me, if any. Additional statement of desires, special provisions, and limitations: None, except as may otherwise be endorsed herein or set out in an attached statement.

You are strongly encouraged to clearly discuss your desires for care at the end of life with your health care agent (the person who will speak for you if you are unable to communicate.)

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH.

- A. General Grant of Power and Authority. Subject to any limitations in this Directive, my agent has the power and authority to do all of the following:
1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.
 2. Execute on my behalf any releases or other documents that may be required in order to obtain this information.
 3. Consent to the disclosure of this information.
 4. Consent to the donation of any of my organs for medical purposes.

[If you want to limit the authority of your agent to receive and disclose information relating to your health, or to limit authority to consent to the donation of any of your organs for medical purposes you must state the limitations in paragraph four (4) "Statement of Desires, Special Provisions, and Limitations" above.]

B. HIPAA Release Authority. My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. § 1320d and 45 CFR §§ 160 through 164.

I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose, and release to my Agent, without restriction, all of my individually identifiable health information and medical records regarding any past, present, or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

The authority given my Agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my Agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

Personal Representative. In addition to the other powers granted by this document, my Agent shall have the power and authority to serve as my Personal Representative for all purposes of the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 04-191), 45 CFR §§ 160 through 164. Each health care provider or Covered Entity is hereby directed to release to my Agent such medical information and financial information as may be requested by them in order for them to perform their respective duties and/or for my Agent to make any decision authorized hereunder.

I hereby waive all financial privacy rights in favor of the Agent. My Agent is also authorized to execute any and all releases and other documents necessary in order to obtain disclosure of

my patient records and other medical information subject to and protected under HIPAA.

Patient Advocate. My Agent shall also be my Patient Advocate or be authorized to appoint a Patient Advocate for me, which may be any other person so designated by my Agent if my Agent does not choose to act in that capacity. My Patient Advocate shall have the same right to ask questions and receive information regarding my medical condition(s), treatment, and any proposed treatment as I would have, and the right to be in attendance at all times.

Copies, faxed, emailed or other evidence of the authority and waiver granted herein may be relied upon as though an original was provided. All of the provisions stated above expressly and specifically apply to any of my psychological and/or psychiatric records, as well as my general medical records.

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES. When necessary to implement the health care decisions that my agent is authorized by this Directive to make, my Agent has the power and authority to execute all of the following on my behalf:

- a. Documents titled or purporting to be a "Refusal to Permit Treatment" and/or a "Leaving Hospital Against Medical Advice," and
- b. Any necessary waiver or release from liability required by a hospital or physician.

7. DESIGNATION OF ALTERNATE AGENTS. *[You may designate alternate agents, but are not required to do so. Any alternate agent you designate will be able to make the same health care decisions as the agent you designated in paragraph one (1), above, in the event that agent is unable or ineligible to act as your agent. If an alternate agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage thereafter is dissolved.]*

If the person designated as my agent in paragraph one (1) is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this Directive. Such persons shall serve in the order listed

below.

A. First Alternate Health Care Agent

Name: _____

Address: _____

Telephone Number: _____

B. Second Alternate Health Care Agent

Name: _____

Address: _____

Telephone Number: _____

C. Third Alternate Health Care Agent

Name: _____

Address: _____

Telephone Number: _____

8. PRIOR DESIGNATIONS REVOKED. I revoke any prior living will and durable power of attorney for health care.

It is my desire that this document, duly executed in Idaho, shall be presumed to comply with the provisions of any similar Act in any other State, and may, in good faith, be relied upon by a health care provider or health care facility in Idaho as well as any other state.

I sign my name to this Statutory Form Living Will and Durable Power of Attorney for Health Care on the date set forth at the beginning of this Form in (City) _____, Idaho.

SIGNATURE

APPENDIX

Idaho Medical Consent and Natural Death Act Idaho Code Title 39, Chapter 45 Effective July 1, 2007

Your signature is all that is required for your Living Will and/or Durable Power of Attorney for Health Care to be valid in Idaho. You may have it witnessed and notarized if you wish.

Register your living will/durable power of attorney document in the Idaho Health Care Directive Registry located in the Office of the Idaho Secretary of State. You may also register your POST form. Once registered you will receive a wallet card with code and password. Now your wishes will be easily accessible to medical personnel in case of an emergency. There is no fee associated with this service. Download the application form at <http://www.idsos.state.id.us/> or call 208.332.2814 and request an application packet.

DEFINITIONS

Artificial life-sustaining procedure

- Any medical procedure or intervention that utilizes mechanical means to sustain or supplant a vital function which when applied to a qualified patient, would serve only to artificially prolong life.
- Does not include the administration of medication or the performance of any medical procedure deemed necessary to alleviate pain

Artificial nutrition and hydration

- Supplying food and water through a conduit, such as a tube or intravenous line, where the recipient is not required to chew or swallow voluntarily.
- Does not include assisted feeding, such as spoon-feeding or bottle-feeding.

Cardiopulmonary resuscitation (CPR)

- Measures to restore cardiac function or to support breathing in the event of cardiac or respiratory arrest or malfunction.
- Includes, but is not limited to, chest compression, delivering electric shock to the chest, or placing tubes in the airway to assist breathing.

Comfort care

- Treatment given in an attempt to protect and enhance quality of life.

Consent to care

- Includes refusal to consent to care and/or withdrawal of care

Health care decision

- Consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical condition.

Palliative Care

World Health Organization: Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. Palliative care:

- Provides relief from pain and other distressing symptoms;

- Affirms life and regards dying as a normal process;
- Intends neither to hasten or postpone death;
- Integrates the psychological and spiritual aspects of patient care;
- Offers a support system to help patients live as actively as possible until death;
- Offers a support system to help the family cope during the patients illness and in their own bereavement;
- Uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- Will enhance quality of life, and may also positively influence the course of illness;
- Is applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications. <http://www.who.int/en/>

Persistent vegetative state

- An irreversible state that has been medically confirmed by a neurological specialist who is an expert in the examination of non-responsive individuals in which the person has intact brain stem function but no higher cortical function and is completely lacking an awareness of self and the external environment.

Terminal condition

- An incurable or irreversible condition that, without the administration of life-sustaining procedures, will, in the opinion of a physician, result in death within a relatively short time.

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*A Better Way Coalition: Life on Our Own Terms has made development of this document possible. A Better Way Coalition is a grassroots, statewide end-of-life coalition committed to promoting compassionate end-of-life care in Idaho.*

*For additional copies of this form, a wallet card, information on advance care planning and end-of-life care visit [www.abetterwaycoalition.org](http://www.abetterwaycoalition.org).*

**Questions about the Idaho Living Will, Durable Power of Attorney for Health Care, and POST can be directed to the Office of the Idaho Attorney General.**

**WILLIAM A. VON TAGEN, Deputy Attorney General,  
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<http://www.idaho.gov/ag>**