HOSPICE OF THE WESTERN RESERVE

Courage in Conversation

Communicating your goals of care and healthcare choices in Ohio

Making Your *Healthcare Choices* Known

THIS WORKBOOK HAS BEEN CREATED FOR ANYONE who is planning for the future and who needs help getting started on some of the difficult questions. Life is full of choices and some of the most important have to do with our own healthcare.

Advance care planning is **making decisions for the healthcare you want to receive should you be unable to speak for yourself**. Advance care planning is not about old age, nor is it important only for those who are seriously ill. Setting your Goals of Care now will ensure you **remain in control of your healthcare choices** in the future.

Planning should be done mindfully and, when possible, while fully engaging those closest to you. To help you and your loved ones have these conversations, the staff of Hospice of the Western Reserve created this booklet. It is a tool to help you think about your healthcare and end-of-life future—what you want and what you don't want; what is vitally important and what is less so. **We hope it is supportive** and that it starts you on the path of planning, sparks conversation and provides you with the necessary forms to legally document your choices.

The conversations you have and **the planning you put in place will be the greatest gifts** to those you love. Your choices, documented and discussed in advance, will give them the confidence to act on your behalf and the comfort of knowing they are honoring your wishes, if they are called upon to do so.

We hope this resource is helpful to you and those you love.

Sincerely,

Bill Finn

William E. Finn
President and Chief Executive Officer

Foreword

MOST PEOPLE AVOID thinking about their own death except in practical terms. It's easiest to concentrate on material things; what to do with the house, car or valuables. If there is wealth to distribute, estate planning can be very complicated. Many of us only need a simple will.

However, the goal of healthcare planning for end-of-life is virtually same for everyone, regardless of financial status. The vast majority of people want the same experience at the end of life and for their dying. When encouraged to think about their own end-of-life, Americans report that **they do not want to be: alone; afraid; in pain; intubated; ventilated or resuscitated**. In short, they want to be peaceful and comfortable.

Most people are also very clear that they want to die at "home." Not in a hospital but in a comfortable, familiar place, surrounded by their loved ones. The unfortunate reality is that 70% of Americans die somewhere other than home.

If most people wish to die at home, why do so many of us pass away in hospitals?

Often, it is because there is a lack of planning, and talking, about end-of-life healthcare. National polls indicate that people believe their loved ones will make sure their end-of-life choices will be honored. At the same time, fewer than 15% have ever discussed those choices with anyone!

All of us at Hospice of the Western Reserve strongly support the development of **advance directives**—living wills, durable powers of attorney for healthcare and organ donation enrollment, if desired. These tools are important but alone are not enough to ensure your healthcare choices will be followed if you are unable to speak for yourself. In addition to the legal documents, it is vital that you appoint agents (advocates) who you trust implicitly and who understand your wishes regarding end-of-life care.

Agents can be family members, friends or professionals such as attorneys or, sometimes, healthcare providers. Agents must be identified in and authorized through the advance directives documents. But that is the final step. Before identifying your agents in writing, you must have an open and honest conversation so that all involved are confident about their roles in fulfilling your end-of-life choices.

Death and dying are inescapable realities. The people who love you the most and who you trust to act as your agent, may be the most uncomfortable discussing your end-of-life choices. Although dying is an uncomfortable topic, there is a good time to bring it up and that is **long before an urgent decision is needed**. Talking about how we want to live as we approach death, and communicating our wishes for end-of-life care while we are not dying, will ease the strain for our loved ones. Future peace of mind is a gift you can give them right now.

This booklet has been created to guide you as you have end-of-life conversations with your loved ones. It also contains helpful resources and State of Ohio Advance Directive forms—legal documents that are ready to complete.

Do not construe this document as legal advice. Seeking counsel is not required, but you might consider consulting an attorney as part of the process.

Frequently Asked Questions

MANY DOCTORS' OFFICES AND CLINICS are now posting signs that ask "Have you completed your advance directives?" and your physician may ask you the same question. But what exactly are "Advance Directives?"

Q: What Makes Up "Advance Directives?"

A: Written advance directives help others accurately remember your healthcare choices and goals of care. They consist of:

- **Healthcare Power of Attorney:** you appoint an agent to make healthcare decisions for you if you are unable to speak for yourself. This does not apply to finances.
- **A Living Will:** provides a narrow set of instructions about care at the end of life.
- **Organ Donation Enrollment**: optional.

Many people assume that their financial power of attorney can make healthcare decisions for them. That is not true. It is necessary to appoint a specific agent, a Healthcare Power of Attorney, to make healthcare decisions on your behalf, if you are unable to speak for yourself. He or she may or may not be the same individual as your financial power of attorney. If you are not able to communicate due to serious injury or illness your loved ones will need to rely on the instructions that appear in your Advance Directives. And, if you have had open conversations with your agent and your loved ones, everyone should be aware of your choices.

But remember, as long as you are capable of making your own decisions, you remain in control of your own medical care. Only in the event that you are unable to speak on your own behalf, your advance directives would guide decision making.

Q: If I have a Healthcare Power of Attorney, do I need a Living Will too?

A: Yes. Most people want to have both documents because they can address different aspects of your medical care. A Living Will allows you to state your wishes regarding life-sustaining medical treatments if you are at the end of life and unable to communicate. A Healthcare Power of Attorney gives you the opportunity to appoint someone you trust to make medical treatment decisions for you in the event you are unable to make or communicate them yourself.

Q: Who should I choose as my agent?

A: Choose someone you trust. They may be a family member, close friend or professional advisor. It is important that he or she understands your choices and is willing to act as an advocate on your behalf.

Q: Is it possible to request that food and water administered by IVs (intravenous tubes) be withheld or withdrawn?

A: Yes. In your Living Will you can state a specific request to have artificially administered food withheld or withdrawn.

Q: How can I address organ donation in my advance directives?

A: You may state your wishes in the document. You also need to complete an organ donor enrollment card. Be sure to share this request with your loved ones. And inform the State of Ohio BMV so your drivers' license or state ID can be marked.

Q: What other documents might I need?

A: Financial planners and estate planning attorneys recommend completing financial documents such as trusts, last will and testament and financial power of attorney. Hospice of the Western Reserve also works with the community and our patients to complete Ethical Wills and Legacy Letters which are personal documents that can be passed to your loved ones.

Q: When can I change my advance directives? How long is it effective?

A: You may change or revoke your documents at any time. It is recommended that you review the forms when you have a change in your health or

life status, such as a life threatening diagnosis or a divorce. Documents are effective for your lifetime unless you change or revoke them.

Q: Where should I keep my advance directives?

A: You should keep your documents in a safe place, making certain your loved ones know where you stored them. Make copies for the agent(s) named in your Healthcare Power of Attorney and other key individuals in your life (i.e., physician, clergy, attorney, loved ones). Have your physician make the forms part of your permanent medical record. Some people, if they are able, choose to bring a copy with them when they are hospitalized. Most hospitals will ask if you have completed advanced directives upon admission.

Q: What if I choose not to complete my advance directives?

A: You put others in the uncomfortable position of making decisions for you, without the knowledge of knowing what you would have wanted. Your healthcare choices may be unknown and unfollowed.

IF YOU ARE READING THIS BOOKLET because you or a loved one has been diagnosed with a serious illness, the following is information regarding hospice care.

Q: What is Hospice Care?

A: Hospice is compassionate, comfort-oriented care for the seriously ill with an emphasis on pain management, symptom control and spiritual and emotional support for the patient and loved ones. A patient qualifies for hospice care when a prognosis of weeks or months, rather than years, to live has been made. Hospice is not a place, it is a philosophy of care.

Hospice of the Western Reserve is one of many hospice care providers in northern Ohio. Care should be sought soon rather than later in the course of a serious illness—not just the last days or weeks of life—to benefit from the full realm of services including:

- 24-hour telephone access to services and support
- Pain management and symptom control
- Medical equipment, tests, procedures, medications and treatments necessary to make our patients comfortable
- Nursing care; experts to help loved ones aclimate to the role of caregiver
- Counseling and social work services
- Expressive therapies, including art and music therapy for patients and family members
- Massage therapy for patients and family members
- State-tested nursing assistants to help with personal care
- Volunteer supportive visits
- Spiritual care
- Palliative care for those not ready for hospice care
- Bereavement services for more than a year following the loss of a loved one

THE FOLLOWING ARE QUESTIONS you should ask any potential hospice care provider AND answers pertaining specifically to Hospice of the Western Reserve.

Q: How long has the hospice been providing care in our community?

A: Hospice of the Western Reserve has been a part of Northern Ohio for nearly 40 years.

Q: Is the hospice staff hospice and palliative care certified?

A: Hospice of the Western Reserve has the most certified staff in the region.

Q: If I need to go into a hospital or nursing home, which ones work with the hospice? Where would the hospice admit your loved one if there was a need for hospitalization?

A: Hospice of the Western Reserve has more than 300 contracts with area hospitals and nursing facilities.

Q: Does the hospice own or operate an in-patient care facility to provide home-like care in a hospice residence?

A: Hospice of the Western Reserve owns and operates three in-patient campuses. Ames Family Hospice House in Westlake; David Simpson Hospice House on Cleveland's lakefront and the Medina Hospice Inpatient Care Unit near I-71.

Q: In a crisis, will staff come to the home at any time, day or night? What about holidays and weekends? Are they available 24 hours a day, 7 days a week?

A: Hospice of the Western Reserve provides:

- A dedicated crisis team that provides continuous care (a Medicare level of care) and will visit where the patient resides, whether it is a residential home, assisted living or nursing facility to provide care during a pain or symptom crisis. To reach this team, call 800.707.8921.
- 24/7 – referral/admission team to admit patients, with same day openings.
- On-call staff available to meet urgent needs, often with a response time of 2 hours or less.
- Administrator on call to respond to your needs NEED PHONE

Q: Is the hospice nonprofit or for-profit?

A: Hospice of the Western Reserve has been not-for-profit since its beginnings in 1978. We are not beholden to shareholders and you can't buy stock in our organization: we answer to the community we serve.

Q: Is the hospice certified by The Joint Commission or Community Health Accreditation Program (CHAP)?

A: Hospice of the Western Reserve is certified by both.

Getting Started

THERE ARE A FEW POINTS to consider as you begin this process.

Planning

Have a plan as to how you will share your wishes. Will you have things written down? Do you want your loved ones to take notes? Who will you share your goals of care and your healthcare choices with?

Environment

Create a comfortable environment that is conducive to listening. Don't try to chat while in the middle of something else. Sit down and be comfortable.

Information

It may be necessary to share your thoughts over several conversations. Be compassionate if your loved one is upset by your honesty but don't apologize for the information you are sharing; these are your choices.

Time

Allow time for your loved ones to process information and respond. This is one of the most important things you can do. They may have questions or feelings to share with you.

Next Steps

Begin to plan your next steps. These may include funeral arrangements, financial arrangements or simply informing your loved ones where your documents are stored.

Sharing your choices through open conversation may be challenging. It is, however, important to be sure your loved ones understand your wishes and are willing and able to speak on your behalf during a difficult time. The more information you provide, the more guidance and comfort they receive and the more certain you can be that your goals of care are met.

Preparing for the Conversation

Defining your wishes for end-of-life care

IT IS IMPORTANT TO GIVE CAREFUL CONSIDERATION for your choices in care. Although not a legal document, use this worksheet to help you define the healthcare choices you want to make and your own goals of care.

1 My Quality of Life

I would like my doctor to try treatments that may restore an acceptable quality of life so that I may do what I feel is important and necessary. On a scale of 1 to 5, with 1 being very important and 5 not important to me, I rate these issues, which define my quality of life:

	VERY IMPORTANT				NOT IMPORTANT
Being able to recognize my family and friends	1	2	3	4	5
Being able to communicate with them and knowing I am understood.	1	2	3	4	5
Having the ability to think clearly	1	2	3	4	5
Being free from pain	1	2	3	4	5
Being free from symptoms most of the time *(nausea, diarrhea, shortness of breath)*	1	2	3	4	5
Being able to eat and drink	1	2	3	4	5
Being able to control my bladder and bowels	1	2	3	4	5
Being able to live in my own home	1	2	3	4	5

2 My Prognosis

If I was very ill and told there was little chance that I would live much longer, it is important that I be able to:

	PLEASE CIRCLE ONE		
Continue with all possible treatments in the hope that a miracle might happen to restore my health	Yes	No	Unsure
Be allowed to die with dignity and given medications to alleviate any pain or discomfort I might have	Yes	No	Unsure

If I were in a coma and my doctors thought there was little hope for regaining consciousness, I would like to:

	PLEASE CIRCLE ONE		
Be kept alive indefinitely in the hope that future medical advancements would restore my health.	Yes	No	Unsure
Have all treatment discontinued, and no new treatment started	Yes	No	Unsure

3 Treatments

These are my choices on possible treatments that can be administered if I should have a terminal illness, dementia or serious stroke or in a coma:

	PLEASE CIRCLE ONE		
Surgery	Yes	No	Unsure
CPR to start my heart or breathing if either should stop	Yes	No	Unsure
Medicine for infections *(antibiotics)*	Yes	No	Unsure
Kidney dialysis	Yes	No	Unsure
A respirator or ventilator to breathe for me	Yes	No	Unsure
Food or water through a tube in my vein, nose or stomach	Yes	No	Unsure
Blood transfusions	Yes	No	Unsure

4 The End of the Journey

My last days are an important time to say, "I love you" "Thank you" and "Goodbye." On a scale of 1 to 5, with 1 being very important and 5 not important to me, I rate these issues, which define how I would like to spend those days:

	VERY IMPORTANT				NOT IMPORTANT
At home	1	2	3	4	5
In a hospital	1	2	3	4	5
Surrounded by family and friends.	1	2	3	4	5
Free from pain and discomfort	1	2	3	4	5
Being alert, even if I might be in pain	1	2	3	4	5
Having time with my pastor, rabbi, priest or other spiritual advisor	1	2	3	4	5
Having time to address forgiveness, gratitude and love	1	2	3	4	5

Now that you have completed this worksheet, which helps to define your healthcare choices, share your choices with the person(s) you've chosen to be your healthcare advocate as identified in your healthcare power of attorney document, as well as other loved ones and your trusted advisors (medical, legal and financial professionals).

☐ **I realize that this is not a legal document, but a tool to help clarify my wishes.**

Signature: ______________________________ Date: ______________

Preparing for the Conversation

Values & Preferences Checklist

CHECK THE BOX THAT BEST DESCRIBES HOW YOU WOULD FEEL IF YOU WERE:	LIFE LIKE THIS WOULD BE:			
	Difficult but acceptable	Worth living, but just barely[A]	Not worth living[B]	Don't know[C]
Unable to walk but able to propel a wheelchair				
Unable to leave home				
In pain most of time				
Uncomfortable most of time (nausea, diarrhea, shortness of breath)				
Depressed or "blue" most of the time				
Fed through a feeding tube				
Needing a breathing machine for each breath, which prevented speech				
Required to have someone around 24 hours daily to care for you				
Unable to control your bladder				
Unable to control your bowels				
Required to live in a nursing home				
Confused and thinking unclearly much of the time				
Unable to recognize family or friends				
Unable to talk and be understood by others				
In a condition that caused your family to feel worried or stressed				
In a condition that caused a severe financial burden on your family				
Other				

[A] If you checked more than one factor, would a combination of these factors make your life "not worth living?" If so, which factors?
[B] Does this mean that you would rather die than be kept alive?
[C] What information or people do you need to help you decide?

Adapted from Your Life, Your Choices, *http://www.mccl.org/document.doc?id=275*

Glossary of Terms

Advance Directives – A general term that describes legal documents: living wills, medical powers of attorney and organ donation enrollment, as appropriate. These documents allow you to give instructions about your future medical care, your end-of-life choices and appoint a person to make healthcare decisions if you are unable to make them yourself. Each state regulates the use of advance directives differently.

Capacity – In the healthcare context, this denotes the ability of the patient to understand and appreciate the nature and consequences of healthcare decisions affecting their outcomes and to make an informed decision. The term "competent" is also used to indicate ability to make informed decisions.

CPR (Cardiopulmonary Resuscitation) – A group of treatments, any or all of which are given to support or restore breathing and circulation if the heart or lungs stop working.

DNR (Do-Not-Resuscitate) Order – A physician's written order instructing healthcare providers not to attempt CPR if the patient stops breathing or the heart stops beating. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of the patient or the person speaking on behalf of the patient, it must be signed by a physician to be valid.

DNR Comfort Care (DNRCC) – is a legally-sanctioned program that is implemented according to a standardized protocol. The DNRCC Order is implemented at different points, depending upon the patient's wishes and must be consistent with reasonable medical standards. There are two options within the DNR Comfort Care Protocol:

- **DNR Comfort Care (DNRCC) Order** – a person receives any care that eases pain and suffering, but no resuscitative measures to save or sustain life from the moment the order is signed by the physician.
- **DNR Comfort Care-Arrest (DNRCC-Arrest) Order** – a person receives standard medical care that may include some components of resuscitation until he or she experiences a cardiac or respiratory arrest.

Healthcare Power of Attorney – A document that allows individuals to appoint someone else to make decisions about their medical care if they are unable to communicate. It may also be called a "healthcare proxy," "durable power of attorney for healthcare," or "appointment of a healthcare agent or surrogate." The person appointed may be called a healthcare agent, surrogate, attorney-in-fact, or proxy.

Hospice care – Comfort-focused care that includes pain and symptom management and emotional and spiritual support. The circle of care also extends to caregivers and loved ones. With the emphasis on comfort rather than cure, loved ones are able to spend time simply being together. Pain is reduced. Anxiety is relieved. For caregivers, the stress of caring for someone with a serious illness is diminished by having a team of compassionate professionals involved.

Life-sustaining Treatment – Treatments (medical procedures) that replace or support an essential bodily function (may also be called life-support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis and others.

Living Will – A type of advance directive in which people document their wishes about future medical treatment if they are at the end of life and unable to communicate. It may also be called a "directive to physicians," "healthcare declaration," or "medical directive." The purpose of a living will is to guide family members and doctors in deciding how aggressively to use medical treatments.

Palliative care – Specialized care for those who have chronic or serious illness, but not necessarily for those facing end-of-life issues. It includes pain and symptom management and support for patients and families.

Withholding or Withdrawing Treatment – Choosing not to have life-sustaining measures or discontinuing them after they have been in use over time.

PRINT YOUR NAME
AND BIRTH DATE

DEFINITIONS

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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

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.

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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.

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.

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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.

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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:

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

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.

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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:

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

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

(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: ___________________

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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.

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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

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.]

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

OTHERWISE, WRITE IN THE GUARDIAN OF YOUR PERSON HERE

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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.**

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:

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.

____

OTHERWISE, WRITE IN THE GUARDIAN OF YOUR ESTATE HERE

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:

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.

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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

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

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.

____
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.

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WITNESS OR NOTARY ACKNOWLEDGEMENT

[Choose One]

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

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_______

Witness Two

Signature: ____

Print Name: ____

Address: ____

Dated: ____________________________ , 20_______

OR

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

Notary Acknowledgment.

State of Ohio
County of ___________________ ss.

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: ____________________

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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

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(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.

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(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.

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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.

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.

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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.

Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

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STATE OF OHIO
LIVING WILL DECLARATION

Notice to Declarant

NOTICE

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.

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.

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PRINT YOUR NAME AND DATE OF BIRTH

State of Ohio
Living Will Declaration
of

____
(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.

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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.

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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.

DEFINITIONS

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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: ____

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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

____

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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.]

____

____

____

____

____

____

____

____

____

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

ATTACH ADDITIONAL PAGES IF NEEDED

[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.]

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

ANATOMICAL GIFT (OPTIONAL)

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.

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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.]*

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

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.

Witness 1

Signature: ____

Print Name: ____

Address: ____

Dated: ____________________________ , 20_______

Witness 2

Signature: ____

Print Name: ____

Address: ____

Dated: ____________________________ , 20_______

OR, if there are no witnesses,

OR

A NOTARY PUBLIC MUST COMPLETE THIS SECTION

NOTARY ACKNOWLEDGMENT

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: ____________________

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Courtesy of CaringInfo
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

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.

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

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OHIO DONOR REGISTRY ENROLLMENT - PAGE 2 OF 2

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

TISSUES

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

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
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

OUR MISSION

Hospice of the Western Reserve
provides palliative and end-of-life care,
caregiver support, and bereavement services
throughout Northern Ohio.
In celebration of the individual worth of each life,
we strive to relieve suffering, enhance comfort,
promote quality of life, foster choice in
end-of-life care, and support
effective grieving.

Serving the Northern Ohio counties of Ashtabula, Cuyahoga, Geauga, Lake, Lorain, Medina, Portage, Summit and Stark.

800.707.8922 | hospicewr.org

Certified Medicare/Medicaid Hospice, Licensed in Ohio
Joint Commission on Accreditation of Healthcare Organizations

If you do not speak English, language assistance services, free of charge, are available to you. Call 216.383.6688.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 216.383.6688.

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