I, ____________________________, want everyone who cares for me to know what health care I desire when I cannot communicate my wishes.

I always expect to be given care and treatment for pain or discomfort even when such care might shorten my life, make me feel like not eating, slow down my breathing or be habit-forming.

I want my doctor to try treatments that may improve my quality of life. By quality of life, I mean living in a way that lets me do the things that are important and necessary to me. Those things are:

______________________________________________________________________________

Examples: The ability to: • recognize family or friends • feed myself • make decisions • take care of myself • communicate

I direct that no treatment be given just to keep me alive when I have:
• a condition that will cause me to die soon or
• a condition, so bad (including substantial brain damage or brain disease) that there is no reasonable hope that I will regain a quality of life acceptable to me (as described above)

When I have one of the above conditions, the treatments I DO NOT WANT include:
• surgery
• doing things to start my heart or breathing, if either stops (CPR)
• medicine to treat infections (antibiotics)
• artificial kidney machine (dialysis)
• breathing machine (respirator, ventilator)
• food and water given through a tube in the vein, nose or stomach (tube feedings)
• chemotherapy (cancer treatment)
• blood transfusions
• other treatment ____________________________

If you DO WANT one or more of the above treatments, circle it and initial at the end of the line.

I want to donate my organs or tissues and realize it may be necessary to maintain my body artificially until my organs can be removed. □ yes □ no □ undecided If yes, determination of patient qualification for donation will be made by the Midwest Organ Bank.

My other directions include: ______________________________________________________

EXAMPLES: • hospice care • death at home, if possible • specific directions regarding organ donation

Talk about this form and your ideas about your health care with the person you have chosen to make decisions for you, your doctor(s), family, friends and clergy. Give each of them a completed copy. You may cancel or change this form at any time.

Signature ____________________________ Date ____________

Witness ____________________________ Date ____________
Durable Power of Attorney for Health Care Decisions:

It is important to choose someone to make health care decisions for you when you cannot. Tell the person (agent) you choose what you would want. The person you choose has the same right as you do to make decisions and to make sure your wishes are honored. If you DO NOT choose someone to make decisions for you, write NONE on the line for agent's name.

I appoint the person named below to be my agent to make health care decisions for me when and only when I cannot make decisions or communicate what I want done. This is a Durable Power of Attorney for Health Care Decisions and the power of my agent shall not end if I become incapacitated or if there is uncertainty that I am dead. This revokes any prior Durable Power of Attorney for Health Care Decisions. My agent may not appoint anyone else to make decisions for me. I, and my estate, hold my agent and my caregivers harmless and protect them against any claim based upon following this Durable Power of Attorney for Health Care or my Health Care Directions. Any costs should be paid from my own resources. I grant to my agent full power to make all decisions for me about my health care, including the power to direct the withholding or withdrawal of life-prolonging treatment. In exercising this power, I expect my agent to be guided by my directions as stated in my Health Care Directions (see reverse side). My agent is also authorized to:

• Consent, refuse or withdraw consent to any care, treatment, service or procedure, (including artificially supplied nutrition and/or hydration/tube feeding) used to maintain, diagnose or treat a physical or mental condition;
• Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home or other health care organization; employ or discharge health care personnel (any person who is authorized or permitted by the laws of the state to provide health care services) as my agent shall deem necessary for my physical, mental or emotional well being;
• Request, receive and review any information regarding my physical or mental health or my personal affairs including medical and hospital records; and to execute any releases of other documents that may be required to obtain such information;
• Move me into or out of any State or institution for the purpose of complying with my Health Care Directions or the decisions of my agent;
• Take any legal action, if needed, to do what I have directed;
• Make decisions about autopsy, organ donation and the disposition of my body;
• Become my guardian if one is needed.

If you DO NOT WANT the person (agent) you name to be able to do any of the above things, draw a line through it and put your initials at the end of the line.

Agent's Name ____________________________ Phone ____________________________
Address ______________________________________________________

If you do not want to name an alternate, write "none."

First Alternate Agent
Name: ____________________________
Address: ____________________________
Telephone: ____________________________

Second Alternate Agent
Name: ____________________________
Address: ____________________________
Telephone: ____________________________

SIGN HERE for the Durable Power of Attorney
Durable Power of Attorney requires notarization.

Signature ____________________________ Date __________
Witness ____________________________ Date __________
Witness ____________________________ Date __________

NOTARIZATION:
On this _______ day of _____________, in the year of ________, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS WHEREOF, I have set my hand and affixed my official seal in the county of __________, State of __________, the date written above.

Notary Public ____________________________ My Commission Expires ____________________________