BARNES-JEWISH Hospital
BJC HealthCare

Washington University in St. Louis
SCHOOL OF MEDICINE

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

(see reverse side for Health Care Directions)

PATIENT IDENTIFICATION

It is important to choose someone to make health care decisions for you when you cannot. ***Tell the person (agent) you choose what care you believe is consistent with your values about life and death.*** *The person you choose has the 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 the agent's name.*

I,_____ (Print Name) 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 disabled or incapacitated. This revokes any prior Durable Power of Attorney for Health Care Decisions. My agent may not appoint anyone else to make decisions for me. My estate and I 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, my agent shall be guided by my directions as stated in my Health Care Directions should I have chosen to complete that document. *(See reverse side).* My agent is also authorized to:

☐ Yes ☐ No ▪ Consent, refuse or withdraw consent to any care, treatment, service or procedure used to maintain, diagnose or treat a physical or mental condition; I specifically authorize my agent to withhold or withdraw artificially supplied nutrition and/or hydration/tube feeding.

☐ Yes ☐ No ▪ 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.

☐ Yes ☐ No ▪ Request, receive, and review any information regarding my physical or mental health, or my personal affairs, including medical and hospital records; execute any releases of other documents that may be required to obtain such information.

☐ Yes ☐ No ▪ 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.

☐ Yes ☐ No ▪ Take legal action, if needed, to do what I have directed.

☐ Yes ☐ No ▪ Make decisions about autopsy and organ donation, and disposition of my body.

Agent's Name:_____ Phone:_____

Address:_____

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

First Alternate Agent
Name_____
Address _____
Phone_____

Second Alternate Agent
Name_____
Address _____
Phone_____

SIGN HERE for the Durable Power of Attorney Form. Many states including Missouri require notarization.

Signature: _____ Date:_____ Time:_____

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 _____, on the date written above.

Notary Public _____ Commission Expires_____

DO NOT WRITE BELOW THIS LINE

BARNES-JEWISH Hospital
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HEALTH CARE DIRECTIONS

(see reverse side for Durable Power of Attorney)

PATIENT IDENTIFICATION

Take a copy of this with you whenever you go to the hospital.

I, _____ (Print Name) want everyone who cares for me to know what health care I want when I cannot make or communicate my decisions.

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 get me back to an acceptable quality of life. By acceptable 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 ▪ make decisions ▪ communicate ▪ feed myself ▪ take care of myself

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 want include (check "yes" or "no"):

Treatment	**Do you want this?**	
Surgery	☐ Yes	☐ No
Doing things to try to start my heart or breathing, if either stops (CPR)	☐ Yes	☐ No
Medicine to treat infections (antibiotics)	☐ Yes	☐ No
Artificial kidney machine (dialysis)	☐ Yes	☐ No
Breathing machine (respirator, ventilator)	☐ Yes	☐ No
Food or water given through a tube in the vein, nose, or stomach (tube feedings or IVs)	☐ Yes	☐ No
Chemotherapy (cancer treatment)	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No
Other: _____	☐ Yes	☐ No

My other preferences for care include: _____

_____

_____

Examples: ▪ hospice ▪ Death at home, if possible

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, and give each of them a completed copy. You may cancel or change this form at any time. You should review it regularly. Each time you review it, put your initials and the date here _____

_____

Sign here for the Health Care Directions: _____ Date:_____ Time:_____

Your Signature

Witness_____ Date:_____ Time:_____ Witness _____ Date:_____ Time:_____

(Witness should not be related to you nor financially connected to you or your estate)

DO NOT WRITE BELOW THIS LINE

BJ 5-3343-1648