SBMR4030

St. Bernards MEDICAL CENTER
The Heart of Great Medicine

ADVANCE CARE PLAN

Patient Name: _____ DOB: _____

Instructions: Competent adults and emancipated minors may give advance instructions using this form or any form of their own choosing. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other healthcare providers when I can no longer make these treatment decisions myself.

Agent: I want the following person to make healthcare decisions for me:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Alternate Agent: If the person named above is unable or unwilling to make healthcare decisions for me, I appoint as alternate:

Name: _____ Phone #: _____ Relation: _____
Address: _____

Quality of Life:

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (**you can check as many of these items as you want**):

- ❑ **Permanent Unconscious Condition**: I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- ❑ **Permanent Confusion**: I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- ❑ **Dependent in all Activities of Daily Living**: I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- ❑ **End Stage Illnesses**: I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen is required most of the time, and activities are limited due to the feeling of suffocation.

Treatment:

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. **Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.**

❑ Yes ❑ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
❑ Yes ❑ No	**Life Support/Other Artificial Support**: Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
❑ Yes ❑ No	**Treatment of New Conditions**: Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
❑ Yes ❑ No	**Tube Feeding/IV Fluids**: Use of tubes to deliver food and water to patient!s stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other end−of−life instructions, such as burial arrangements, hospice care, etc:

_____
_____
_____

(Attach additional pages if necessary)

Organ donation (optional): Upon my death I wish to make the following anatomical gift (please mark one):
❑ Any organ tissue ❑ My entire body ❑ Only the following organ tissues: _____
_____
_____

Psychiatric Care:

Please indicate whether you intend for this Advance Care Plan to extend to psychiatric care.

❑ Yes. The Agent(s) named in this Advance Care Plan has the authority to make psychiatric care decisions for me if I can no longer make psychiatric care decisions for myself.

❑ No. The Agent(s) named in this Advance Care Plan does not have the authority to make psychiatric care decisions for me if I can no longer make psychiatric care decisions for myself.

Additional Instructions: The lists provided by you below will help your Agent(s) make psychiatric care decisions for you.

List any psychiatric medications that you specifically do not wish to receive (for example, any medication that has previously caused you to have a bad reaction):

_____
_____
_____

List any psychiatric treatment that you do not want to receive (for example, behavior therapy, group psychotherapy, electroconvulsive therapy, or pharmacotherapy):

_____
_____
_____

(Attach additional pages if necessary)

SIGNATURE

Your signature should either be witnessed by two competent adults **OR** notarized. If witnessed, neither witness should be the person you appointed as your Agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.
Signature: _____ Date/Time: _____
DOB: _____ Phone #: _____
Witnesses:

1. I am a competent adult who is not named as the Agent. I witnessed the patient's signature on this form.

_____
Signature of Witness Number 1 Date/Time


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2. I am a competent adult who is not named as the Agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of Witness Number 2, Date/Time

This document may be notarized instead of witnessed.

STATE OF ARKANSAS
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ Signature of Notary Public: _____

WHAT TO DO WITH THIS ADVANCE CARE PLAN

❑ Provide a copy to your physician(s)
❑ Keep a copy in your personal files where it is accessible to others
❑ Tell your closest relatives and friends what is in your document
❑ Provide a copy to the person(s) you named as your healthcare agent

APPOINTMENT OF HEALTHCARE AGENT
(ARKANSAS)

I, _____, give my Agent named below permission to make healthcare decisions for me if I cannot make decisions for myself, including any healthcare decision that I could have made for myself if able. If my Agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

Agent:	Alternate:
_____ Name	_____ Name
_____ Address	_____ Address
_____ City, State, Zip Code	_____ City, State, Zip Code
(_____)_____ Area Code Home Phone Number	(_____)_____ Area Code Home Phone Number
(_____)_____ Area Code Work Phone Number	(_____)_____ Area Code Work Phone Number
(_____)_____ Area Code Mobile Phone Number	(_____)_____ Area Code Mobile Phone Number
_____ Patient's Name (please print or type), Date/Time	_____ Patient's Name (please print or type), Date/Time

_____
Signature of Patient (must be at least 18 or emancipated minor) Date/Time

_____
Patient DOB, Phone #

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To be legally valid, **either** block A **OR** block B must be properly completed and signed

Block A Witnesses (2 witnesses required)

1. I am a competent adult who is not named as the Agent. I witnessed the patient's signature on this form.

_____
Signature of Witness number 1, Date/Time

2. I am a competent adult who is not named above. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of Witness number 2, Date/Time

Block B Notarization

STATE OF ARKANSAS
COUNTY OF _____

I am a Notary Public in and for the state and county named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient". The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ Signature of Notary Public _____