PENNSYLVANIA

ADVANCE

DIRECTIVES

Legal Documents
To Assure Future Health Care Choices

ADVANCE DIRECTIVES

YOUR RIGHT TO MAKE HEALTH CARE DECISIONS UNDER THE LAW IN PENNSYLVANIA

INTRODUCTION

Pennsylvania and federal law give every competent adult, 18 years or older, the right to make their own health care decisions, including the right to decide what medical care or treatment to accept, reject or discontinue. If you do not want to receive certain types of treatment or wish to name someone to make health care decisions for you, you have the right to make these desires known to your doctor, hospital or other health care providers, and in general, have these rights respected. You also have the right to be told about the nature of your illness in terms that you can understand, the general nature of the proposed treatments, the risks of failing to undergo these treatments and any alternative treatments or procedures that may be available to you.

However, there may be times when you cannot make your wishes known to your doctor or other health care providers. For example, if you were taken to a hospital in a coma, would you want the hospital's medical staff to know what your specific wishes are about the medical care that you want or do not want to receive.

This book describes what Pennsylvania and federal law have to say about your rights to inform your health care providers about medical care and treatment you want, or do not want, and about your right to select another person to make these decisions for you, if you are physically or mentally unable to make them yourself.

To make these very difficult issues easier to understand, we have presented the information in the form of questions and answers. Because this is an important matter, we urge you to talk to your spouse, family, close friends, personal advisor, your doctor and your attorney before deciding whether or not you want an advance directive.

QUESTIONS AND ANSWERS

GENERAL INFORMATION ABOUT ADVANCE DIRECTIVES

What are "Advance Directives"?

Advance directives are documents which state your choices about medical treatment or name someone to make decisions about your medical treatment if you are unable to make these decisions or choices yourself. They are called "advance" directives, because they are signed in advance to let your doctor and other health care providers know your wishes concerning medical treatment. Through advance directives, you can make legally valid decisions about your future medical care.

Pennsylvania law recognizes 4 types of advance directives:

1) A Living Will Declaration.
2) A Durable Power of Attorney for Health Care.
3) A Mental Health Care Declaration.
4) A Mental Health Power of Attorney.

Do I have to have an Advance Directive?

No. It is entirely up to you whether you want to prepare any documents. But if questions arise about the kind of medical treatment that you want or do not want, advance directives may help to solve these important issues. Your doctor or any health care provider cannot require you to have an advance directive in order to receive care; nor can they prohibit you from having an advance directive. Moreover, under Pennsylvania law, no health care provider or insurer can charge a different fee or rate depending on whether or not you have executed an advance directive.

What will happen if I do not make an Advance Directive?

You will receive good medical care even if you do not have any advance directives. However, there is a greater chance that you will receive more treatments or more procedures than you may want.

If you cannot speak for yourself and you do not have any advance directives, your doctor or other health care providers will look to the following people in the order listed for decisions about your care:

1) Your spouse; 2) An adult child; 3) Either of your parents; 4) An adult brother or sister; 5) An adult grandchild; or 6) An adult who has knowledge of your preferences, values and religious beliefs.

How do I know what treatment I want?

Your doctor must inform you about your medical condition and what different treatments can do for you. Many treatments have serious side effects. Your doctor must give you information, in language that you can understand, about serious problems that medical treatment is likely to cause. Often, more than one treatment might help you and different people might have different ideas on which is best. Your doctor can tell you the treatments that are available to you, but he or she cannot choose for you. That choice depends on what is important to you.

Whom should I talk to about Advance Directives?

Before writing down your instructions, you should talk to those people closest to you and who are concerned about your care and feelings. Discuss them with your family, your doctor, friends and other appropriate people, such as a member of your clergy or your lawyer. These are the people who will be involved with your health care, if you are unable to make your own decisions.

When do Advance Directives go into effect?

It is important to remember that these directives only take effect when you can

no longer make your own health care decisions. As long as you are able to give "informed consent," your health care providers will rely on **YOU** and **NOT** on your advance directives.

What is "Informed Consent"?

Informed consent means that you are able to understand the nature, extent and probable consequences of proposed medical treatments and you are able to make rational evaluations of the risks and benefits of those treatments as compared with the risks and benefits of alternate procedures **AND** you are able to communicate that understanding in any way.

How will health care providers know if I have any Advance Directives?

All hospitals, nursing homes, home health agencies, HMO's and all other health care facilities that accept federal funds must ask if you have an advance directive, and if so, they must see that it is made part of your medical records.

Will my Advance Directives be followed?

Generally, yes, if they comply with Pennsylvania law. Federal law also requires your health care providers to give you their written policies concerning advance directives. A summary statement of those policies is provided for you at the back of this book. It may happen that your doctor or other health care provider cannot or will not follow your advance directives for moral, religious or professional reasons, even though they comply with Pennsylvania law. If this happens, they must immediately tell you. Then they must also help you transfer to another doctor or facility that will do what you want.

Can I change my mind after I write an Advance Directive?

Yes. At any time, you can cancel or change any advance directive that you have written. To cancel your directive, simply destroy the original document and tell your family, friends, doctor and anyone else who has copies that you have cancelled them. To change your advance directives, simply write and date a new one. Again, give copies of your documents to all the appropriate parties, including your doctor.

Do I need a lawyer to help me make an Advance Directive?

A lawyer may be helpful, and you might choose to discuss these matters with him or her, but there is no legal requirement in Pennsylvania to do so. You may use the form that is provided in this booklet to execute your advance directives.

Can I provide for organ donation in my Pennsylvania Advance Directives?

Yes. Pennsylvania law now provides that you can include a statement concerning your wishes to donate your tissues and organs in the advance directive document included in this booklet. You do **NOT** have to donate your organs after death to fill out the advance directive document.

Will my Pennsylvania Advance Directives be valid in another state?

The laws on advance directives differ from state to state, so it is unclear whether a Pennsylvania advance directive will be valid in another state. Because an advance

directive is a clear expression of your wishes about medical care, it will influence that care no matter where you are admitted. However, if you plan to spend a great deal of time in another state, you should consider executing an advance directive that meets all the legal requirements of that state.

Will Advance Directives from another state be valid in Pennsylvania?

Yes. An advance directive executed in compliance with another state's laws will be valid in Pennsylvania to the extent permitted by Pennsylvania law.

What should I do with my Advance Directives?

You should keep them in a safe place where your family members can get to them. Do **NOT** keep the original copies in your safe deposit box. Give copies of these documents to as many of the following people as you are comfortable with: your spouse and other family members; your doctor; your lawyer; your clergyperson; and any local hospital or nursing home where you may be residing. Another idea is to keep a small wallet card in your purse or wallet which states that you have an advance directive and who should be contacted. Wallet cards are provided for you at the back of this book.

LIVING WILL DECLARATION

What is a "Living Will"?

A living will is a document which tells your doctor or other health care providers whether or not you want life-sustaining treatments or procedures administered to you if you are in an end-stage condition or in a permanently unconscious state. It is called a "living will" because it takes effect while you are still living.

Is a "Living Will" the same as a "Will" or "Living Trust"?

No. Wills and living trusts are financial documents which allow you to plan for the distribution of your financial assets and property after your death. A living will only deals with medical issues while you are still living. Wills and living trusts are complex legal documents and you usually need legal advice to execute them. You do not need a lawyer to complete your Pennsylvania living will.

When does a Pennsylvania Living Will go into effect?

A Pennsylvania living will goes into effect when: 1) your doctor has a copy of it, and 2) your doctor has concluded that you are no longer able to make your own health care decisions, and 3) your doctor has determined that you are in a permanently unconscious state or you are in an end-stage condition.

What are "life-sustaining" treatments?

These are treatments or procedures that are not expected to cure your terminal condition or make you better. They only prolong dying. Examples are mechanical respirators which help you breathe, kidney dialysis which clears your body of wastes, and cardiopulmonary resuscitation (CPR) which restores your heartbeat.

What is a "permanently unconscious" state?

A permanently unconscious state means that a patient is in a permanent coma caused by illness, injury or disease. The patient is totally unaware of himself or herself, his or her surroundings and environment, and to a reasonable degree of medical certainty, there can be no recovery.

What is an "end-stage" condition?

An end-stage condition is defined as an irreversible condition caused by injury, illness or disease which results in severe and permanent deterioration, incapacity and physical dependence, and to a reasonable degree of medical certainty, medical treatment would not be effective.

Is a Living Will the same as a "Do Not Resuscitate (DNR)" order?

No. A Pennsylvania living will covers almost all types of life-sustaining treatments and procedures. A "Do Not Resuscitate (DNR)" order covers two types of life-threatening situations. A DNR order is a document prepared by your doctor at your direction and placed in your medical records. It states that if you suffer cardiac arrest (your heart stops beating) or respiratory arrest (you stop breathing), your health care providers are not to try to revive you by any means.

Will I receive medication for pain?

Unless you state otherwise in the living will, medication for pain will be provided where appropriate to make you comfortable and will not be discontinued.

Can my doctor be sued or prosecuted for carrying out the provisions of a valid Pennsylvania Living Will?

No. Pennsylvania law states that no physician, health care facility, or any person acting under the direction of the physician can be subject to criminal prosecution, civil action, or can be found guilty of unprofessional conduct for carrying out the provisions of a valid Pennsylvania living will.

Is a Pennsylvania Living Will effective if a woman is pregnant?

Pennsylvania law generally does not allow a doctor or other health care provider to honor the living will of a pregnant woman who has directed that she not be kept alive. The terms of such a living will may be honored, however, if the woman's doctor determines that life-sustaining treatment: 1) will not maintain the woman in a manner that will allow for the continued development and birth of the unborn child; 2) will physically harm the pregnant woman; or 3) cause her pain which could not be relieved by medication.

If your living will is not honored because you are pregnant, the Commonwealth must pay all usual, customary and reasonable expenses of your care.

Does a Pennsylvania Living Will affect insurance?

No. The making of a living will, in accordance with Pennsylvania law, will not affect

the sale or issuance of any life insurance policy, nor shall it invalidate or change the terms of any insurance policy. In addition, the removal of life-support systems shall not, for any purpose, constitute suicide, homicide or euthanasia, nor shall it be deemed the cause of death for the purposes of insurance coverage.

Does a Pennsylvania Living Will have to be signed and witnessed?

Yes. You must sign (or have someone sign the document in your presence and at your direction, if you are unable to sign) and date the living will. Then it must be witnessed by 2 qualified people, 18 years or older, or notarized. The only people who **CANNOT** witness your signature of the living will are: 1) Any person who signed the living will on your behalf if you were unable to sign; or 2) Any health care provider or his or her agent if they provide health care services to you.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE

What is a Durable Power of Attorney for Health Care (DPAHC)?

A DPAHC is a legal document which allows you (the "principal") to appoint another person (the "agent" or "attorney-in-fact") to make medical decisions for you if you should become temporarily or permanently unable to make those decisions yourself. The person you choose as your attorney-in-fact does not have to be a lawyer.

Who can I select to be my Agent?

You can appoint almost any adult to be your agent. You should select a person(s) knowledgeable about your wishes, values, religious beliefs, in whom you have trust and confidence, and who knows how you feel about health care. You should discuss the matter with the person(s) you have chosen and make sure that they understand and agree to accept the responsibility.

Members of your family, such as your spouse, adult children, brother or sister, or even a close friend are usually good choices to be your agent. If you appoint your spouse, and then become divorced, the appointment of your spouse as your agent is revoked. The only people who **CANNOT** be appointed as your agent are: 1) Your attending physician or other health care provider unless he or she is related to you by blood, marriage or adoption; or 2) An owner, operator or employee of a health care facility in which you are receiving care, unless he or she is related to you by blood, marriage, or adoption.

When does the DPAHC take effect?

The DPAHC only becomes effective when you are temporarily or permanently unable to make your own health care decisions and your agent consents to start making those decisions. Your agent will begin making decisions after your doctors have decided that you are no longer able to make them. Remember, as long as you are able to make treatment decisions, you have the right to do so.

What decisions can my Agent make?

Unless you limit his or her authority in the DPAHC, your agent will be able to

make almost every treatment decision in accordance with accepted medical practice that you could make, if you were able to do so. If your wishes are not known or cannot be determined, your agent has the duty to act in your best interest in the performance of his or her duties. These decisions can include authorizing, refusing or withdrawing treatment, even if it means that you will die. As you can see, the appointment of an agent is a very serious decision on your part.

What happens if I regain the capacity to make my own decisions?

If your doctor determines that you have regained the capacity to make or to communicate health care decisions, then two things will happen:

1) Your agent's authority will end; and 2) Your consent will be required for treatment.

If your doctor later determines that you no longer have the capacity to make or to communicate health care decisions, then your agent's authority will be restored.

Can there be more than one Agent?

Yes. While you are not required to do so, you may designate alternates who may also act for you, if your primary agent is unavailable, unable or unwilling to act. Your alternates have the same decision-making powers as your primary agent.

Can I appoint more than one person to share the responsibility of being my Agent?

You should appoint only **ONE** person to be your primary agent. Any others that you want to be involved with your health care decisions should be appointed as your alternates. If two or more people are given equal authority and they disagree on a health care decision, one of the most important purposes of the DPAHC--to clearly identify who has the authority to speak for you--will be defeated. If you are afraid of offending people close to you by choosing one over another to be your agent, ask them to decide among themselves who will be your primary agent and select the others as alternates.

Can my Agent be liable for decisions made on my behalf?

No. Your agent or your alternates cannot be held liable for treatment decisions made in good faith on your behalf. Also, he or she cannot be held liable for costs incurred for your care, just because he or she is your agent.

Does the DPAHC have to be signed and witnessed?

Yes. You must sign (or have someone sign the DPAHC in your presence and at your direction, if you are unable to sign) and date it. Then it must be witnessed by two qualified people, 18 years or older, or notarized.

The only people who **CANNOT** witness your signature of the DPAHC are: 1) Any person who signed the DPAHC on your behalf if you were unable to sign; or 2) Any health care provider or his or her agent if they provide health care services to you.

MENTAL HEALTH CARE DECLARATION

What is a Mental Health Care Declaration (MHCD)?

A MHCD is a legal document which allows you to tell your doctor and other health care providers about your preferences and instructions regarding mental health care treatment, if you are no longer able to make these decisions yourself.

What is "Mental Health Care Treatment"?

Mental health care treatment is defined by Pennsylvania law to include, among others: 1) Electroconvulsive treatment (Examples might include electroshock therapy or drugs which can produce convulsions); 2) Psychoactive drugs (drugs which work on your central nervous system); 3) Admission to and retention in a facility for the care of mental illness; and 4) Participation in experimental studies and drug trials.

Where can I get a MHCD form?

Because of space limitations, the MHCD form suggested by Pennsylvania law has not been provided in this booklet. You should contact your doctor or other health care provider to get a copy of the suggested document, or you can send $4.00 and a self-addressed stamped envelope to Professional Media Resources, P.O. Box 460380, St. Louis, MO 63146 and the document will be mailed to you.

MENTAL HEALTH POWER OF ATTORNEY

What is a Mental Health Power of Attorney (MHPOA)?

A MHPOA is a document which allows you (the "Principal") to appoint another person (the "Agent") to make mental health care decisions for you if you should become temporarily or permanently unable to make those decisions yourself. It is similar to the durable power of attorney, but it only deals with mental health care.

Who can I select to be my Agent?

You can appoint almost any adult to be your agent. You should select a person(s) knowledgeable about your wishes, values, religious beliefs, in whom you have trust and confidence and who knows how you feel about mental health care. You should discuss the matter with the person(s) you have chosen and make sure that they understand and agree to accept the responsibility.

You can select a member of your family, such as your spouse, child, brother or sister, or a close friend. If you select your spouse and then become divorced, the appointment of your spouse as your agent is revoked.

Where can I get a MHPOA form?

Because of space limitations, the MHPOA form suggested by Pennsylvania law has not been provided in this booklet. You can purchase the suggested document by visiting our website at www.advdir.com and the document (available in English only) will be mailed to you.

PENNSYLVANIA DURABLE HEALTH CARE POWER OF ATTORNEY AND HEALTH CARE TREATMENT INSTRUCTIONS

PART I

INTRODUCTORY REMARKS ON HEALTH CARE DECISION MAKING

You have the right to decide the type of health care you want.

Should you become unable to understand, make or communicate decisions about medical care, your wishes for medical treatment are most likely to be followed if you express those wishes in advance by:

1) Naming a health care agent to decide treatment for you; and

2) Giving health care treatment instructions to your health care agent or health care provider.

An advance health care directive is a written set of instructions expressing your wishes for medical treatment. It may contain a health care power of attorney, where you name a person called a "health care agent" to decide treatment for you, and a living will, where you tell your health care agent and health care providers your choices regarding the initiation, continuation, withholding or withdrawal of life-sustaining treatment and other specific directions.

You may limit your health care agent's involvement in deciding your medical treatment so that your health care agent will speak for you only when you are unable to speak for yourself or you may give your health care agent the power to speak for you immediately. This combined form gives your health care agent the power to speak for you only when you are unable to speak for yourself. A living will cannot be followed unless your attending physician determines that you lack the ability to understand, make or communicate health care decisions for yourself and you are either permanently unconscious or you have an end-stage medical condition, which is a condition that will result in death despite the introduction or continuation of medical treatment. You, and not your health care agent, remain responsible for the cost of your medical care.

If you do not write down your wishes about your health care in advance, and if later you become unable to understand, make or communicate these decisions, those wishes may not be honored because they may remain unknown to others.

A health care provider who refuses to honor your wishes about health care must tell you of its refusal and help to transfer you to a health care provider who will honor your wishes.

You should give a copy of your advance health care directive (a living will, health care power of attorney or a document containing both) to your health care agent, your physicians, family members and others whom you expect would likely attend to your needs if you become unable to understand, make or communicate decisions about medical care. If your health care wishes change, tell your physician and write a new advance health care directive to replace your old one. It is important in selecting a health care agent that you choose a person you trust who is likely to be available in a medical situation where you cannot make decisions for yourself. You should inform that person that you have appointed him or her as your health care agent and discuss your beliefs and values with him or her so that your health care agent will understand your health care objectives.

You may wish to consult with knowledgeable, trusted individuals such as family members, your physician or clergy when considering an expression of your values and health care wishes. You are free to create your own advance health care directive to convey your wishes regarding medical treatment. The following form is an example of an advance health care directive that combines a health care power of attorney with a living will.

NOTES ABOUT THE USE OF THIS FORM

If you decide to use this form or create your own advance health care directive, you should consult with your physician and your attorney to make sure that your wishes are clearly expressed and comply with the law.

If you decide to use this form but disagree with any of its statements, you may cross out those statements.

You may add comments to this form or use your own form to help your physician or health care agent decide your medical care.

This form is designed to give your health care agent broad powers to make health care decisions for you whenever you cannot make them for yourself. It is also designed to express a desire to limit or authorize care if you have an end-stage medical condition or are permanently unconscious. If you do not desire to give your health care agent broad powers, or you do not wish to limit your care if you have an end-stage medical condition or are permanently unconscious, you may wish to use a different form or create your own. You should also use a different form if you wish to express your preferences in more detail than this form allows or if you wish for your health care agent to be able to speak for you immediately. In these situations, it is particularly important that you consult with your attorney and physician to make sure that your wishes are clearly expressed.

This form allows you to tell your health care agent your goals if you have an end-stage medical condition or other extreme and irreversible medical condition, such as advanced Alzheimer's disease. Do you want medical care applied aggressively in these situations or would you consider such aggressive medical care burdensome and undesirable?

You may choose whether you want your health care agent to be bound by your instructions or whether you want your health care agent to be able to decide at the time what course of treatment the health care agent thinks most fully reflects your wishes and values.

If you are a woman and diagnosed as being pregnant at the time a health care decision would otherwise be made pursuant to this form, the laws of this Commonwealth prohibit implementation of that decision if it directs that life-sustaining treatment, including nutrition and hydration, be withheld or withdrawn from you, unless your attending physician and an obstetrician who have examined you certify in your medical record that the life-sustaining treatment:

1) Will not maintain you in such a way as to permit the continuing development and live birth of the unborn child;
2) Will be physically harmful to you; or
3) Will cause pain to you that cannot be alleviated by medication.

A physician is not required to perform a pregnancy test on you unless the physician has reason to believe that you may be pregnant.

Pennsylvania law protects your health care agent and health care providers from any legal liability for following in good faith your wishes as expressed in the form or by your health care agent's direction. It does not otherwise change professional standards or excuse negligence in the way your wishes are carried out. If you have any questions about the law, consult an attorney for guidance.

This form and explanation is not intended to take the place of specific legal or medical advice for which you should rely upon your own attorney and physician.

PART II DURABLE HEALTH CARE POWER OF ATTORNEY

I, ______________________________________, of ______________________________

County, Pennsylvania, appoint the person named below to be my health care agent to make health and personal care decisions for me.

Effective immediately and continuously until my death or revocation by a writing signed by me or someone authorized to make health care treatment decisions for me, I authorize all health care providers or other covered entities to disclose to my health care agent, upon my agent's request, any information, oral or written, regarding my physical or mental health, including, but not limited to, medical and hospital records and what is otherwise private, privileged, protected or personal health information, such as health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 110 Stat. 1936), the regulations promulgated thereunder and any other State or local laws and rules. Information disclosed by a health care provider or other covered entity may be redisclosed and may no longer be subject to the privacy rules provided by 45 C.F.R. Pt. 164.

The remainder of this document will take effect when and only when I lack the ability to understand, make or communicate a choice regarding a health or personal care decision as verified by my attending physician. My health care agent may not delegate the authority to make decisions.

My health care agent has all of the following powers subject to the health care treatment instructions that follow in Part III (cross out any powers you do not want to give your health care agent):

1. To authorize, withhold or withdraw medical care and surgical procedures.
2. To authorize, withhold or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries or veins.
3. To authorize my admission to or discharge from a medical, nursing, residential or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.
4. To hire and fire medical, social service and other support personnel responsible for my care.
5. To take any legal action necessary to do what I have directed.
6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.

APPOINTMENT OF HEALTH CARE AGENT

I appoint the following health care agent:

____

(Name and Relationship)

____

(Address)

____

(Home Telephone Number) (Work Telephone Number) (E-mail)

If you do not name a health care agent, health care providers will ask your family or an adult who knows your preferences and values for help in determining your wishes for treatment. Note that you may not appoint your doctor or other health care provider as your health care agent unless related to you by blood, marriage or adoption.

If my health care agent is not readily available or if my health care agent is my spouse and an action for divorce is filed by either of us after the date of this document, I appoint the person or persons named below in the order named. (It is helpful, but not required, to name alternative health care agents.)

____
(First Alternative Health Care Agent Name and Relationship)

____
(Address)

____
(Home Telephone Number) (Work Telephone Number) (E-mail)

____
(Second Alternative Health Care Agent Name and Relationship)

____
(Address)

____
(Home Telephone Number) (Work Telephone Number) (E-mail)

GUIDANCE FOR HEALTH CARE AGENT (OPTIONAL)

If I have an end-stage medical condition or other extreme irreversible medical condition my goals in making medical decisions are as follows (insert your personal priorities such as comfort, care, preservation of mental function, etc.): ______________________

____

____

____

SEVERE BRAIN DAMAGE OR BRAIN DISEASE

If I should suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such a condition intolerable and the application of aggressive medical care to be burdensome. I therefore request that my health care agent respond to any intervening (other and separate) life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated below. (Initial as appropriate)

_____ I agree _____ I disagree

PART III LIVING WILL

HEALTH CARE TREATMENT INSTRUCTIONS IN THE EVENT OF END STAGE MEDICAL CONDITION OR PERMANENT UNCONSCIOUSNESS

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing

evidence of my wishes to be followed when I lack the capacity to understand, make or communicate my treatment decisions:

If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious such as an irreversible coma or an irreversible vegetative state and there is no realistic hope of significant recovery, all of the following apply (cross out any treatment instructions with which you do not agree):

1. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming.
2. I direct that all life prolonging procedures be withheld or withdrawn.
3. I specifically do not want any of the following as life prolonging procedures: (if you wish to receive any of these treatments, write "I do want" after the treatment)

Heart-lung resuscitation (CPR) ____________________

Mechanical ventilator (breathing machine) ____________________

Dialysis (kidney machine) ____________________

Surgery ____________________

Chemotherapy ____________________

Radiation treatment ____________________

Antibiotics ____________________

TUBE FEEDINGS

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestines, arteries, or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery.

(initial only one statement)

______ I want tube feedings to be given.

OR

______ I do not want tube feedings to be given.

HEALTH CARE AGENT'S USE OF INSTRUCTIONS

(initial one option only)

______ My health care agent must follow these instructions.

OR

______ These instructions are only guidance.

My health care agent shall have final say and may override any of my instructions.

(Indicate any exceptions) ____________________

____

If I did not appoint a health care agent, these instructions shall be followed.

LEGAL PROTECTION

Pennsylvania law protects my health care agent and health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form

or in complying with my health care agent's direction. On behalf of myself, my executors and heirs, I further hold my health care agent and my health care providers harmless and indemnify them against any claim for their good faith actions in recognizing my health care agent's authority or in following my treatment instructions.

ORGAN DONATION

(initial one option only)

______ I consent to donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education. (Insert any limitations you desire on donation of specific organs or tissues or uses for donation of organs and tissues.) ______________

____

OR

______ I do not consent to donate my organs or tissues at the time of my death.

SIGNATURE

Having carefully read this document, I have signed it this ______ day of ______________, 20________, revoking all previous health care powers of attorney and health care treatment instructions.

____

(Sign full name here for Health Care Power of Attorney and Health Care Treatment Instructions)

WITNESS SIGNATURES

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)

____

(Witness)

____

(Witness)

NOTARY

(optional)

(Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other states.)

On this _____ day of ________________________, 20_____, before me personally appeared the aforesaid declarant and principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

In witness whereof, I have hereunto set my hand and affixed my official seal in the County of ____________________________, State of ______________________________ the day and year first above written.

____

(Notary Public)

My commission expires: ____

A SUMMARY STATEMENT OF HEALTH CARE POLICIES REGARDING PATIENTS' RIGHTS OF SELF-DETERMINATION

(Since a summary like this cannot answer all possible questions or cover every circumstance, you should discuss any remaining questions with a representative of this health care facility.)

1. Prior to the start of any procedure or treatment, the physician shall provide the patient with whatever information is necessary for the patient to make an informed judgment about whether the patient does or does not want the procedure or treatment performed. Except in an emergency, the information provided to the patient to obtain the patient's consent shall include, but not necessarily be limited to, the intended procedure or treatment, the potential risks, and the probable length of disability. Whenever significant alternatives of care or treatment exist, or when the patient requests information concerning alternatives, the patient shall be given such information. The patient shall have the right to know the person responsible for all procedures and treatments.

2. The patient may refuse medical treatment to the extent permitted by law. If the patient refuses treatment, the patient will be informed of significant medical consequences that may result from such action.

3. The patient will receive written information concerning his or her individual rights under Pennsylvania state law to make decisions concerning medical care.

4. The patient will be given information and the opportunity to make advance directives including, but not limited to, a Pennsylvania Living Will Declaration, a Durable Power of Attorney for Health Care, a Mental Health Care Declaration, and a Mental Health Power of Attorney.

5. The patient shall receive care regardless of whether or not the patient has or has not made an advance directive.

6. The patient shall have his or her advance directive(s), if any has been created, made a part of his or her permanent medical record.

7. The patient shall have all of the terms of his or her advance directive(s) complied with by the health care facility and caregivers to the extent required or allowed by Pennsylvania law.

8. The patient shall be transfered to another doctor or health care facility if his or her doctor(s), or agent of his or her doctor(s), or the health care facility cannot respect the patient's advance directive requests as a matter of "conscience".

9. The patient may telephone the following for questions or complaints concerning these advance directive policies:

Home Health Agencies - 800-222-0989

Convalescent Homes - 800-254-5164 Hospitals - 717-783-8980

WALLET CARDS FOR PENNSYLVANIA ADVANCE DIRECTIVES

Complete and cut out the cards below. Put the cards in the wallet or purse you carry most often, along with your driver's license or health insurance card. **NOTE: Please be sure to make a copy of page 6 of 6 (the reverse page of this one) before cutting these wallet cards or you will be cutting out part of the last page of the Advance Directive Document.**

ATTN: PENNSYLVANIA HEALTH CARE PROVIDERS

____
(Your Name)

I have created the following **Advance Directives**:
(Check one or more)

______ **Pennsylvania Living Will**
______ **Durable Power of Attorney for Health Care**
______ **Mental Health Care Declaration**
______ **Mental Health Care Power of Attorney**

Please contact ____________________________
(Name)
and ____________________ for more information.
(Telephone)

PENNSYLVANIA ORGAN DONOR CARD

____
(Your Name)

I have donated an anatomical gift, if medically acceptable, in my Pennsylvania Living Will dated ______________.

Please contact ____________________________
(Name)
at ____________________________
(Address)
and ____________________ for more information.
(Telephone)

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