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Patient Information
Concerning Advance Directives

What kind of medical care would you want if you were too ill or hurt to express your wishes? Advance directives are legal documents that tell your doctor, health care professionals, family and friends your wishes about your health care ahead of time. There are also documents which can be used to appoint someone to make decisions for you if you cannot do so yourself. You can say "yes" to treatment you want and "no" to treatment you don't want.

Types of advance directives available in Nevada are:

- **Durable Power of Attorney for Health Care**
  This enables someone you name to make decisions concerning your health care if you become incapable of doing so yourself.
- **Declaration**
  This directs any attending physician to withhold or withdraw treatment which only prolongs the process of dying, when you have an incurable and irreversible condition. There is also a declaration designating another person to decide to withhold or withdraw life-sustaining treatment.
- **Do-Not-Resuscitate Order**
  Written by your physician at your direction, this advises health care professionals that you do not wish to undergo CPR if your heart stops beating or if you were to stop breathing.
- **Physician Order for Life-Sustaining Treatment**
  This is a detailed document outlining the different types of life-sustaining treatments you would accept or refuse in certain situations.

Medical Treatment Terms

It is important to know the kinds of life-prolonging care to consider if using advanced directives. There are three kinds to consider: cardiopulmonary resuscitation (CPR), artificial provision of nutrition and fluids (tube-feeding), and active treatment to fight disease.

<u>Life-resuscitating treatment</u>

In Nevada, "life-resuscitating treatment" means cardiopulmonary resuscitation (CPR) or a component of CPR, including chest compressions, defibrillation, assisted ventilation, airway intubation, or administration of drugs or electric current to restore your heart's rhythm.

Cardiopulmonary resuscitation is the act of reviving someone whose heart and/or breathing have stopped. CPR can include basic and advanced measures.

The basic measures are:

- Cardiac compression (repeatedly pressing on the chest to squeeze the heart so that blood begins to circulate again)
- Mouth-to-mouth breathing, to push air into the lungs

The advanced measures are:

- Intubation (putting a tube through the mouth or nose into the windpipe) and attaching a machine or device to do artificial breathing

The following is the form of a “Declaration,” provided for under Nevada Statues:

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct any attending physician, pursuant to NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:

> Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of gastrointestinal tract after all other treatment is withheld pursuant to this declaration . . . . |_____|

Signed this _________________ day of _____________, 19______.

Signature: ______________________________

Address: ________________________________

____

____

The declarant voluntarily signed this writing in my presence.

Witness: ________________________________

Address: ________________________________

Witness: ________________________________

Address: ________________________________

The following is the form of a "Declaration," provided for under Nevada Statues **designating another person** to decide to withhold or withdraw life-sustaining treatment:

DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I appoint ____________________, or if he or she is not reasonably available or is unwilling to serve, _____________________________________, to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain, pursuant to NRS 449.535 to 449.690, inclusive. (If the person or persons I have so appointed are not reasonably available or are unwilling to serve, I direct my attending physician, pursuant to those sections, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.) *Strike language in parenthesis if you do not desire it.*

If you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:

> Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of gastrointestinal tract after all other treatment is withheld pursuant to this declaration . . . . |_____|

Signed this _________________ day of _____________, 19______.

Signature: ______________________________

Address: _________________________________

____

The declarant voluntarily signed this writing in my presence.

Witness: _________________________________
Address: _________________________________
____

Witness: _________________________________
Address: _________________________________
____

Name and address of each designee.

Name: _________________________________
Address: _________________________________
____

Name: _________________________________
Address: _________________________________
____

The following is the form of a "Durable Power of Attorney for Health Care Decisions" provided for under Nevada Statute:

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document. It creates a Durable Power of Attorney for Health Care. Before executing the document you should know these important facts:

1. This document gives the person you designate as your Attorney-in-Fact the power to make health care decisions for you. The power is subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any types of treatment or placements that you do not desire.

2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known, or, if your desires are unknown, to act in your best interest.

3. Except as you otherwise specify in this document, the power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.

4. Unless you specify a shorter period in this document, this Power will exist indefinitely from the date you execute this document and if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health care decisions for yourself.

5. Notwithstanding this document, you have the right to make medical and other health care decisions for yourself so long as your can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection, and health care necessary to keep you alive may not be stopped if you object.

6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.

7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other provider of health care orally or in writing.

8. The person designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

9. This document revokes any prior Durable Power of Attorney for Health Care.

10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

1. DESIGNATION OF HEALTHCARE AGENT

I, ________________________________(insert your name) do hereby designate and appoint:

Name:

Address:

Telephone Number:

as my attorney-in-fact to make health care decisions for me as authorized in this document.

(Insert the mane and address of the person you wish to designate as your attorney-in-fact to make health care decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact: (1) your treating provider of health care; (2) an employee of your treating provider of health care; (3) an operator of a health care facility; or (4) an employee of an operator of a health care facility.)

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this document, I intend to create a Durable Power of Attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power, and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

4. SPECIAL PROVISIONS AND LIMITATIONS

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on your attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this Durable Power of attorney for Health Care, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

____

____

5. DURATION

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this Power of Attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this Power of Attorney end on the following date:

6. STATEMENT OF DESIRES

(With respect to decisions to withhold or withdraw life sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decisions that is in your best interest. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.)

a. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures…...|____|

b. If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.)................................|____|

c. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, and sections 2 to 12, inclusive, if this subparagraph is initialed.)……………………………………….........|____|

d. Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastrointestinal tract after all other treatment is withheld...........|____|

e. I do not desire treatment to be provided and/or continue if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life..|____|

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want and circling the answer you prefer.

Other or Additional Statements of Desires:

____

____

____

____

7. DESIGNATION OF ALTERNATE ATTORNEY-IN-FACT

(You are not required to designate any alternative attorney-in-fact but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1 to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such person to service in the order listed below:

A. First Alternative Attorney-in-Fact

Name: ____
Address: ____
____
Telephone Number: ____

B. Second Alternative Attorney-in-Fact

Name: ____
Address: ____
____
Telephone Number: ____

8. PRIOR DESIGNATIONS REVOKED

I revoke any prior Durable Power of Attorney for Health Care:

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY.)

I sign my name to this Durable Power of Attorney for HealthCare on __________________(date)

at _______________________(city), ____(state).

____
(Signature)

(This power of attorney will not be valid for making health care decisions unless it is either (1) signed by at least two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature, or (2) acknowledged before a notary public.)

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

(You may use acknowledgment before a notary public instead of statement of witnesses.)

State of Nevada)
: ss:
County of ______________)

On this _________ day of ________________, in the year ________, before me, ______________________________(here insert name of notary public) personally appeared ______________________________ (here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

NOTARY SEAL

____
(Signature of Notary Public)

STATEMENT OF WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness (1) a person you designate as the attorney-in-fact; (2) a provider of health care; (3) an employee of a provider of health care; (4) the operator of a health care facility; (5) an employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged the Durable Power of Attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a provider of health care, an employee of a provider of health care, the operator of a community care facility, nor an employee of an operator of a health care facility.

Signature: ____

Print Name: ____

Residence Address: ____

____

Date: _________________________

Signature: ____

Print Name: ____

Residence Address: ____

____

Date: __________________________

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and the to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: ____

Signature: ____

Names: ________________________________ Address: ______________________________________

Print Name: ____________________________ ______________________________________

Date: __________________________________ ______________________________________

COPIES: You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be available so a copy may be given to your providers of health care.

Under NRS 449.628, a health care provider is allowed to transfer care of a patient to another provider if the first provider objects on the basis of conscience to implementation of an advance directive.

NEVADA POLST (Physician Order for Life-Sustaining Treatment)

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY

Faxed, copied or electronic versions of a Nevada POLST are legal and valid

SIDE 1: Medical Orders

Consult this form when patient lacks decisional capacity. It is intended to be honored by any health-care provider who treats the patient in any health-care setting, including, without limitation, a residence, health care facility or the scene of a medical emergency (NRS 449.694.). A section not completed does not invalidate the rest and indicates full treatment for that section.

Last Name/First/Middle Initial		
Date of Birth (dd/mm/yr)	Last 4 SSN	Gender
/ /	__ __ __ __	M F

Section A — CPR — Check one only

CARDIOPULMONARY RESUSCITATION (CPR). *Patient/resident has no pulse & is not breathing.*

☐ Attempt Resuscitation (CPR)
(See Section B: Full Treatment required)

☐ Allow Natural Death (Do Not Attempt Resuscitation)
If available, EMS-DNR #:____________________

When not in cardiopulmonary arrest follow orders in Section B

Section B — Interventions

MEDICAL INTERVENTIONS. *Patient/resident has pulse and/or is breathing.*
Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped.

1. ☐ **Comfort Measures Only.** The patient/resident is treated with dignity, respect and kept clean, warm and dry. Reasonable measures are made to offer food and fluids by mouth as tolerated, and attention is paid to hygiene. Medication, positioning, wound care and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction may be used as needed for comfort. These measures are to be used where the patient/resident lives. Transfer only if comfort needs cannot be met in current location.
*Other Instructions:*____

2. Limited Medical Interventions. Comfort measures always provided.

a. Life-Sustaining Antibiotics.

☐ No antibiotics. Use other measures to relieve symptoms
☐ Administer antibiotics by mouth as necessary
☐ Administer antibiotics IV as necessary

*Other Instructions:*____

b. Artificially Administered Fluids and Nutrition.

☐ No feeding tube
☐ Defined trial period of feeding tube
☐ Long term feeding tube
☐ No IV fluids
☐ Defined trial period of IV fluids
☐ Long term IV fluids

*Other Instructions:*____

c. Other Limitations of Medical Interventions.

☐ No intensive care admission
☐ No x-ray
☐ No IV (assure agreement with **a.** & **b.** above)
☐ No hyperalimentation
☐ No electrolyte or acid/base corrective measures
☐ No lab work
☐ No antiarrhythmic drugs
☐ No dialysis

*Other Instructions:*____

3. ☐ **Full Treatment.** Includes care above plus endotracheal intubation and cardioversion.
*Additional Instructions:*____

Section C — Physician Signature

Date **(Required)**	Physician Signature **(Required)**	Physician Name (Print)

Physician Office Address	Physician Phone	Physician License No.

Send original with patient when discharged or transferred

NEVADA POLST (Physician Order for Life-Sustaining Treatment)

Patient Name:_______________________________________ **DOB:**___________

SIDE 2: Supplementary Patient Preferences

Section	
Section D Organ Donation	**ORGAN DONATION** ☐ I have documented on my license or state issued ID that I would like to donate my organs *Other Instructions*:____
Section E Advance Directive	**The following documents/persons have further information regarding patient's/resident's preferences:** **1.** Advance Directive (AD): Living Will, Declaration, Durable Power of Attorney (DPOA) for Health Care ☐ NO ☐ YES **If no AD, skip to #2 below** AD Registered with Secretary of State: ☐ NO ☐ YES - Registration No:_______________ Other location: ______________________________ Appointed Agent #1: ______________________ Telephone No:_______________ Appointed Agent #2: ______________________ Telephone No:_______________ **2.** If no agent appointed, another person will make decisions for you as determined by Nevada law. **3.** Court-Appointed Guardian ☐ NO ☐ YES Name:_______________________ Telephone No: ____________________
Section F Signatures	**Patient / Agent / Parent / Guardian** (circle one) **Approval** I have discussed this form, its treatment options and their implications for sustaining life with my / the patient's health care provider. This form reflects my treatment preferences. Signature:_______________________________________ Date: __________ **Consent for Sections A and B above were discussed with and given by:** ☐ Patient ☐ Spouse ☐ Adult Child ☐ Court-Appointed Guardian ☐ Parent of Minor ☐ Health Care Agent (DPOA) ☐ Other:_______________ Witnessed by (for any checked above):______________________ Date:___________ **Preparer's Information** Preparer's Name (print):______________________________ Date:___________ Signature of Person Preparing Form:_________________________________
Section G Registry	Physician initial box to right to verify that information has been provided to the patient to submit their completed and signed POLST form to the Living Will Lockbox. Authorization forms can be found at: www.LivingWillLockbox.com. ☐

GENERAL INSTRUCTIONS

- Record all treatments entered on this POLST as orders in patient's chart.
- Copy POLST form for patient record.
- If orders change complete a new POLST and write VOID across this POLST.
- If no new form is completed, full treatment and resuscitation may be provided.
- Transfer or discharge patient with a current POLST form.

WHEN THIS FORM SHOULD BE REVIEWED

This form (POLST) should be reviewed periodically and if:

- The patient/resident is transferred from one care setting or level to another, or
- There is a substantial change in patient/resident health status, or
- The patient/resident treatment preferences change.

THE LASTEST VERSION OF THE POLST FORM IS AVAILABLE FROM THE NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH.

Send original with patient when transferred or discharged

For Internal Use