ADVANCE HEALTH CARE DIRECTIVE

You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your supervising health care provider. If you use this form, you may complete or modify all or any part of it. You are free to use a different form, but you should make sure it is effective under Wyoming law before using it.

Part 1 of this form is a power of attorney for health care.

- Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable.

- You may also name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you by blood, marriage or adoption, your agent may not be an owner, operator or employee of a residential or community care facility at which you are receiving care.

- Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:
    - Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;
    - Select or discharge health care providers and institutions;
    - Approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and
    - Direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

Part 2 of this form lets you give specific instructions about any aspect of your health care.

Choices are provided for you to express your wishes regarding the provision, withholding or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

Part 3 of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 of this form lets you designate a supervising health care provider to have primary responsibility for your health care.

After completing this form, sign and date the form at the end. This form must either be signed before a notary public or, in the alternative, be witnessed by two (2) witnesses that meet the criteria set out above the witness signature line. Give a copy of the signed and completed form to your physician, to any other health care providers you may have, to any health care institution at which you are receiving care, and to any health care agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this all or any part of this advance health care directive at any time and in any manner (except the designation of an agent), or replace this form at any time. You have the right to change the designation of your agent at any time, but the change must be made in a written, signed document. You must be legally competent to revoke or replace this advance heath care directive, or change your agent designation.

St. John's Medical Center is not giving any legal advice by providing you with this form. You are encouraged to seek your own legal counsel regarding this form, or any other advance health care directive.

PART 1
POWER OF ATTORNEY FOR HEALTH CARE

(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:

____

(name of individual you choose as agent)

____

(address) (city) (state) (zip code)

____

(home phone) (work phone)

OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able or reasonably available to make a health care decision for me, I designate as my first alternate agent:

____

(name of individual you choose as first alternate agent)

____

(address) (city) (state) (zip code)

(home phone) (work phone)

OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able or reasonably available to make a health care decision for me, I designate as my second alternate agent:

(name of individual you choose as second alternate agent)

(address) (city) (state) (zip code)

(home phone) (work phone)

(2) AGENT'S AUTHORITY: My agent is authorized to make ALL health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive, EXCEPT as I state here:

(Add additional sheets if needed.)

(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I lack the capacity to make my own health care decisions unless I initial the following box. If I regain capacity, my agent's authority will become ineffective. If I initial this box [ ], my agent's authority to make health care decisions for me takes effect immediately and will remain effective until I revoke it.

(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown; my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

(5) NOMINATION OF GUARDIAN: If a guardian of my person needs to be appointed for me by a court, (please initial one):

[ ] I nominate the agent(s) whom I named in this form in the order designated to act as guardian.

[ ] I nominate the following to be guardian In the order designated:

[ ] I do not nominate anyone to be guardian.

PART 2
INSTRUCTIONS FOR HEALTH CARE

Please strike any wording that you do not want.

(6) END-OF-LIFE DECISIONS: I direct that my health care providers and others involved in my care provide, withhold or withdraw treatment in accordance with the choice I have initialed below:

Choice Not To Prolong Life
I do not want my life to be prolonged if:
[ ] I have an incurable and irreversible condition that will result in my death within a relatively short time,
[ ] I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, OR
[ ] the likely risks and burdens of treatment would outweigh the expected benefits

OR

Choice to Prolong Life
[ ] I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

(7) ARTIFICIAL NUTRITION AND HYDRATION: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (6) unless I initial the following box. If I initial this box [ ], artificial nutrition must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

(8) RELIEF FROM PAIN: Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times: ______________________________

____

____

____

____

(9) OTHER WISHES: (If you do not agree with any of the optional choices above and wish to write your own, or if you wish to add to the instructions you have given above, you may do so here.) I direct that (please cross out those which do not apply):

My Wish For How Comfortable I Want To Be:

- If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my caregivers to do whatever they can to help me.
- I wish to have a cool moist cloth put on my head if I have a fever.
- I want my lips and mouth kept moist to stop dryness.
- I wish to have warm baths often. I wish to be kept fresh and clean at all times.
- I wish to be massaged with warm oils as often as I can be.
- I wish to have my favorite music played when possible until my time of death.

- I wish to have personal care like shaving, nail clipping, hair brushing, and teeth brushing, as long as they do not cause me pain or discomfort.
- I wish to have religious readings and well-loved poems read aloud when I am near death.
- I wish to know about options for hospice care to provide medical, emotional and spiritual care for me and my loved ones.

My Wish for How I Want People to Treat Me:

- I wish to have people with me when possible. I want someone to be with me when it seems that death may come at any time.
- I wish to have my hand held and to be talked to when possible, even if I don't seem to respond to the voice or touch of others.
- I wish to have others by my side praying for me when possible.
- I wish to have the members of my faith community told that I am sick and asked to pray for me and visit me.
- I wish to be cared for with kindness and cheerfulness, and not sadness.
- I wish to have pictures of my loved ones in my room, near my bed.
- If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.
- I want to die in my home, if that can be done.

My Wish for What I Want My Loved Ones to Know:

- I wish to have my family and friends know that I love them.
- I wish to be forgiven for the times I have hurt my family, friends, and others.
- I wish to have my family, friends and others know that I forgive them for when they may have hurt me in my life.
- I wish for my family and friends to know that I do not fear death itself. I think it is not the end, but a new beginning for me.
- I wish for all of my family members to make peace with each other before my death, if they can.
- I wish for my family and friends to think about what I was like before I became seriously ill. I want them to remember me in this way after my death.
- I wish for my family and friends and caregivers to respect my wishes even if they don't agree with them.
- I wish for my family and friends to look at my dying as a time of personal growth for everyone, including me. This will help me live a meaningful life in my final days.
- I wish for my family and friends to get counseling if they have trouble with my death. I want memories of my life to give them joy and not sorrow.
- After my death, I would like my body to be (circle one): buried or cremated.
- My body or remains should be put in the following location:________________________________
- The following person knows my funeral wishes:________________________________

If anyone asks how I want to be remembered, please say the following about me:

____

____

____

____

If there is to be a memorial service for me, I wish for this service to include the following (list music, songs, readings or other specific requests that you have):

____
____
____
____
____
____
____

(Add additional sheets if needed.)

PART 3
DONATION OF ORGANS AT DEATH

(OPTIONAL)

(10) Upon my death (initial applicable box):

[ ] I give my body, or
[ ] I give any needed organs, tissues or parts, or
[ ] I give the following organs, tissues or parts only:

____

My gift is for the following purposes (strike any of the following you do not want):

- Any purpose authorized by law
- Transplantation
- Therapy
- Research
- Medical education

PART 4
DESIGNATION OF SUPERVISING HEALTHCARE PROVIDER

I designate the following physician as my primary physician:

____
(name of physician)

____
(address) (city) (state) (zip code)

____
(phone)

If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I authorize the attending physician assigned to my care to act as my primary physician.

(12) EFFECT OF COPY: A copy of this form has the same effect as the original.

(13) SIGNATURES: Sign and date the form here:

(sign your name)

(date)

(print your name)

(address, city, state)

SIGNATURES OF WITNESSES (either 2 witnesses, OR a notary public must sign this document):
First witness (cannot be your treating health care provider or the provider's employee, the attorney-in-fact appointed in Part 1, or the operator or employee of a community care or residential care facility caring for you):

I declare under penalty of perjury that the person who signed or acknowledged this document is known to me to be the principal, and the principal signed or acknowledged this document in my presence.

(print name)

(address)

(signature of witness)

(date)

Second witness (cannot be your treating health care provider or the provider's employee, the attorney-in-fact appointed in Part 1, or the operator or employee of a community care or residential care facility caring for you):

I declare under penalty of perjury that the person who signed or acknowledged this document is known to me to be the principal, and the principal signed or acknowledged this document in my presence.

(print name)

(address)

(signature of witness)

(date)

Signature of notary public in lieu of witnesses (either 2 witnesses, OR a notary public must sign this document):

(print name)

(address)

(signature of notary)

(date)

ADDITIONAL INFORMATION, optional.