Golden Valley Memorial HEALTHCARE
1600 N. Second | Clinton, MO 64735
660.885.5511 | gvmh.org

Health Care Directions

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

I, _____ SS# XXX-XX- _____Birth date _____ want everyone who cares for me to know what healthcare I want when I cannot let others know what I want.

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:
- Recognize family or friends
- Make decisions
- Feed myself
- Take care of myself
- Communicate

I direct that no treatment be given just to keep me alive when I have a:

- Condition that will cause me to die soon
- 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 the above conditions exist: (initial your choice)	I WANT	I DO NOT WANT
• Surgery	_____	_____
• Doing things to start my heart or breathing if either stops (CPR)	_____	_____
• Medicine to treat infections (antibiotics)	_____	_____
• Artificial kidney machine (dialysis)	_____	_____
• Breathing machine (respirator, ventilator)	_____	_____
• Food or water given through a tube in the vein, nose or stomach (tube feedings)	_____	_____
• Nose or stomach (tube feedings)	_____	_____
• Chemotherapy (cancer treatment)	_____	_____
• Blood transfusions	_____	_____
• Other treatment_____		

I want to donate my organs or tissues and realize it may be necessary to maintain my body artificially until my organs can be removed. ☐ Yes ☐ No ☐ Undecided

My other directions include:

_____

_____

Examples: Hospice care death at home, if possible; specific directions regarding organ donation

Talk about this form and your ideas about your healthcare 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 every so often. Each time you review it, put your initials and the date here.

_____

Durable Power of Attorney for Health Care Decisions

It is important to choose someone to make health care decisions for you when you cannot. Tell the person (agent) you choose what you would want. The person you choose has the same 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 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 Healthcare Decisions and the power of my agent shall not end if I become incapacitated or if there is uncertainty that I am dead. This revokes any prior Durable Power of Attorney for Healthcare Decisions. My agent may not appoint anyone else to make decisions for me. I and my estate hold my agent and my caregivers harmless and protect them against any claim based upon following this Durable Power of Attorney for Healthcare of my Healthcare 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 healthcare, including the power to direct the withholding or withdrawal of life-prolonging treatment. In exercising this power, I expect my agent to be guided by my directions as stated in my Healthcare Directions. My agent is also authorized to:

- Consent, refuse or withdraw consent to any care, treatment, service or procedure (including artificially supplied nutrition and/or hydration/tube feeding) used to maintain, diagnose or treat a physical or mental condition.
- Make all necessary arrangements for any hospital, psychiatric treatment facility, hospice, nursing home or other healthcare organization; employ or discharge healthcare 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.
- 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.
- Move me into or out of any state or institution for the purpose of complying with my Healthcare Directions or the decisions of my agent.
- Take legal action, if needed, to do what I have directed.

- Make decisions about autopsy, organ donation and the disposition of my body.
- Become my guardian if one is needed.

If you DO NOT want the person (agent) you name to be able to do any of the above things, draw a line through it, and put your initials at the end of the line.

Agent's name: _____ Phone: _____
Address: _____

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

First Alternate Agent
Name: _____
Address: _____
Phone: _____

Second Alternate Agent
Name: _____
Address: _____
Phone: _____

SIGN HERE for the Durable Power of Attorney and/or Healthcare Directions forms. Many states require notarization. Please ask two (2) persons to witness your signature who are not related to you nor financially connected to you or your estate.

Signature: _____ Date: _____
Witness: _____ Date: _____
Witness: _____ Date: _____

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: _____