HEALTH CARE TREATMENT DIRECTIVE

I, _____ make this Health Care Treatment Directive to exercise my right
Print Resident Name
to determine the course of my health care and to provide clear and convincing proof of my treatment decisions **when I lack the capacity to make or communicate my decisions** and there is no realistic hope that I will regain such capacity.

If my physician believes that a certain life prolonging procedure or other health care treatment may provide me with comfort, relieve pain or lead to a significant recovery, I direct my physician to try the treatment for a reasonable period of time However, if such treatment proves to be ineffective, I direct treatment be withdrawn even if so doing may shorten my life.

I direct I be given health care treatment to relieve pain or to provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

I direct all life prolonging procedures be withheld or withdrawn when there is no hope of significant recovery, and I have: **1)** a terminal condition, **2)** a condition, disease or injury without reasonable expectation that I will regain an acceptable quality of life, or **3)** substantial brain damage or brain disease which cannot be significantly reversed.

1. When any of the above conditions exist, I DO NOT WANT the life prolonging procedures which I have initialed below. **You should assume any treatments NOT initialed may be administered.**

   - Antibiotics Initial _____
   - Dialysis Initial _____
   - Heart-Lung resuscitation (CPR) Initial _____
   - Mechanical ventilator (Respirator) Initial _____
   - Surgery Initial _____
   - Tube feedings of food and water in vein, nose, or stomach Initial _____

2. I make other instructions as follows: (Describe what is minimally acceptable quality of life to you.)

_____

_____

_____

If you do NOT wish to name an agent as referred to on the accompanying Durable Power of Attorney for Health Care Decisions, initial here _____, and write NONE in the space for agent's name and sign.

Discuss this document and your ideas about quality of life with your agent, physician(s), family members friends and clergy and provide them with a signed copy (original or photocopy). *You may revoke or change this document. Periodic review is recommended. If there are no changes after each review, initial and date in the margin.*

DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

This is a Durable Power of Attorney for Health Care Decisions, and the authority of my agent shall not terminate if I become incapacitated. I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in my Health Care Treatment Directive or otherwise known to my agent. My agent's authority to interpret my desires is intended to be as broad as possible and any that expenses incurred should be paid by my resources. My agent may not delegate the authority to make decisions. My agent is authorized as follows to:

If there is a statement in paragraphs 1 through 6 below with which you do not agree, draw a line through it and add your initials.

1. Consent, refuse or withdraw consent to any care, treatment, service or procedure, (including artificially supplied nutrition and/or hydration by tube feedings) used to maintain, diagnose or treat a physical or medical condition.
2. Make decisions regarding organ donation, autopsy and the disposition of my body.
3. Make all necessary arrangements for any hospital, psychiatric hospital or treatment facility, nursing home or similar institution; to employ or discharge heal care personnel (any person who is, licensed, certified or otherwise authorized or permitted by the law of the State of Kansas to administer health care) as the agent shall deem necessary for my physical, mental and emotional well being.
4. Request, receive and review any information, verbal or written, regarding my personal affairs or physical or mental health including medical and hospital records and to exempt any releases of other documents that may be required in order to obtain such information.
5. Move me into or out of any state for the purpose of complying with my Health Care Treatment Directive or the decisions of my agent
6. Take any legal action reasonably necessary to do what I have directed.

I appoint the following person to be my agent to make health care decisions for me WHEN AND ONLY WHEN I lack the capacity to make or communicate a choice regarding a particular health care decision and my Health Care Treatment Directive does not adequately cover circumstances. I request that the person serving as my agent be my guardian if one is needed.

If you do not wish to name an agent, write, NONE in the space provided below

AGENT'S NAME (Resident) _____

ADDRESS _____ TELEPHONE _____

If my agent is not available or not willing to make health care decisions for me, I appoint the person or persons named below in the order named if more than one is listed as my agent.

FIRST ALTERNATE AGENT

Name _____

Address _____

Telephone _____

SECOND ALTERNATE AGENT

Name _____

Address _____

Telephone _____

Protection of Persons Who Rely on My agent: I and my estate hold my agent and my caregivers harmless and protect them against any claim for following this durable power of attorney.
Severability: If any part of this document is held to be unenforceable under law, I direct that all of the other provisions of the document shall remain in force and effect.

_____

X SIGNATURE _____ DATE _____

Witness _____ Date _____ Witness _____ Date _____