

ADVANCE DIRECTIVES

**Planning Ahead: How to Make
Future Healthcare Decisions *NOW***



For more information, please contact either:

Memorial Hospital Belleville
4500 Memorial Drive
Belleville, IL 62226
Pastoral Care (618) 257-5291
Social Services (618) 257-5420

Memorial Hospital East
1404 Cross Street
Shiloh, IL 62269
Pastoral Care (618) 607-3100
Social Services (618) 607-3139

Thank you for entrusting your healthcare needs to The Memorial Network. Memorial wants you and your family to know about Memorial's policy to comply with the law. You have the right to make decisions regarding your care. In support of this policy, Memorial recognizes your right to:

1. Make informed decisions about your health care.
2. Accept or refuse treatment.
3. Make decisions about end of life care.
4. Complete or not complete advance directives. You will not be discriminated against nor will your care be dependent on your completing an Advance Directive.

An Advance Directive in Illinois includes a Healthcare Power of Attorney, Living Will, Practitioner Orders for Life-Sustaining Treatment (POLST), and Mental Health Power of Attorney. The Health Care Power of Attorney and Living Will forms are available in this booklet. However, the POLST and Mental Health POA forms are available upon request.

This booklet contains legal statements from the Illinois Department of Public Health on the various types of Advance Directives. In order to assist you, the booklet contains common questions and answers along with the forms should you decide to complete them.

If you decide to complete the forms, please provide a copy to a representative so that we can place a copy on your chart for this visit and future visits. If you change any part of your advance directive, it is important that you notify your care providers by providing them updated copies. Finally, if you or your family have any questions about Memorial's Advance Directive policy, our staff will refer you to personnel who may assist you.

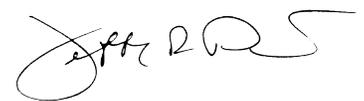
Sincerely,



Terri Halloran, RN, PhD
Vice President, Patient Care Services/CNO



Cassidy Hoelscher, MHA, LNHA, LPTA
Administrator, Memorial Care Center



Jeffrey Dossett, Administrator
Memorial Hospital East



NOTICE TO THE INDIVIDUAL SIGNING THE POWER OF ATTORNEY FOR HEALTH CARE

No one can predict when a serious illness or accident might occur. When it does, you may need someone else to speak or make health care decisions for you. If you plan now, you can increase the chances that the medical treatment you get will be the treatment you want.

In Illinois, you can choose someone to be your “health care agent.” Your agent is the person you trust to make health care decisions for you if you are unable or do not want to make them yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of agent in writing. The written form is often called an “advance directive.” You may use this form or another form, as long as it meets the legal requirements of Illinois. There are many written and on-line resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing your advance directive.

WHAT ARE THE THINGS I WANT MY HEALTH CARE AGENT TO KNOW?

The selection of your agent should be considered carefully, as your agent will have the ultimate decision making authority once this document goes into effect. In most instances, this will be after you are no longer able to make your own decisions. While the goal is for your agent to make decisions that keep with your preferences, in the majority of circumstances, that is what happens. Please know that the law does allow your agent to make decisions to direct or refuse health care interventions or withdraw treatment. Your agent will need to think about conversations you have had, your personality, and how you handled important health care issues in the past. Therefore, it is important to talk with your agent and your family about such things as:

- a) What is most important to you in your life?
- b) How important is it to you to avoid pain and suffering?
- c) If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?
- d) Would you rather be at home or in a hospital for the last days or weeks of your life?
- e) Do you have religious, spiritual, or cultural beliefs that you want your agent and others to consider?
- f) Do you wish to make a significant contribution to medical science after your death through organ or whole body donation?
- g) Do you have an existing advanced directive, such as a living will, that contains your specific wishes about health care that is only delaying your death? If you have another advance directive, make sure to discuss with your agent the directive and the treatment decisions contained within that outline your preferences. Make sure that your agent agrees to honor the wishes expressed in your advance directive.



WHAT KIND OF DECISIONS CAN MY AGENT MAKE?

If there is ever a period of time when your physician determines that you cannot make your own health care decisions, or if you do not want to make your own decisions, some of the decisions your agent could make are to:

- a) Give permission for medical tests, medicines, surgery, or other treatments.
- b) Choose where you receive care and which physicians and others provide it.
- c) Decide to authorize, refuse, or withdraw treatment, even if it means that you will die. You may choose to include guidelines and/or restrictions to your agent's authority.
- d) Agree or decline to donate your organs or your whole body if you have not already made this decision yourself. This could include donation for transplant, research, and/or education. You should let your agent know whether you are registered as a donor in the First Person Consent registry maintained by the Illinois Secretary of State or whether you have agreed to donate your whole body for medical research and/or education.
- e) Decide what to do with your remains after you have died, if you have not already made plans.
- f) Talk with your other loved ones to help come to a decision (but your designated agent will have the final say over your other loved ones).
- g) Have complete access to your medical and mental health records and the authority to share them with others as needed.
- h) Communicate with your physician(s) and other health care providers on any matter and has the ability to require an opinion as to whether or not you lack the ability to make decisions for yourself.

Your agent is not automatically responsible for your health care expenses.

WHOM SHOULD I CHOOSE TO BE MY HEALTH CARE AGENT?

You can pick a family member, but you do not have to. Your agent will have the responsibility to make medical treatment decisions, even if other people close to you might urge a different decision. The selection of your agent should be done carefully, as he or she will have ultimate decision-making authority for your treatment decisions once you are no longer able to voice your preferences. Choose a family member, friend, or other person who:

- a) Is at least 18 years old;
- b) Knows you well;
- c) You trust to do what is best for you and is willing to carry out your wishes, even if he or she may not agree with your wishes;
- d) Would be comfortable talking with and questioning your physicians and other health care providers;
- e) Would not be too upset to carry out your wishes if you became very sick; and
- f) Can be there for you when you need it and is willing to accept this important role.



WHAT IF MY AGENT IS NOT AVAILABLE OR IS UNWILLING TO MAKE DECISIONS FOR ME?

If the person who is your first choice is unable to carry out this role, then the second agent you chose will make the decisions; if your second agent is not available, then the third agent you chose will make the decisions. The second and third agents are called your successor agents and they function as back-up agents to your first choice agent and may act only one at a time and in the order you list them.

WHAT WILL HAPPEN IF I DO NOT CHOOSE A HEALTH CARE AGENT?

If you become unable to make your own health care decisions and have not named an agent in writing, your physician and other health care providers will ask a family member, friend, or guardian to make decisions for you. In Illinois, a law directs which of these individuals will be consulted. In that law, each of these individuals is called a “surrogate.”

There are reasons why you may want to name an agent rather than rely on a surrogate:

- a) The person or people listed by this law may not be who you would want to make decisions for you.
- b) Some family members or friends might not be able or willing to make decisions as you would want them to.
- c) Family members and friends may disagree with one another about the best decisions.
- d) Under some circumstances, a surrogate may not be able to make the same kinds of decisions that an agent can make.

WHAT IF THERE IS NO ONE AVAILABLE WHOM I TRUST TO BE MY AGENT?

In this situation, it is especially important to talk to your physician and other health care providers and create written guidance about what you want or do not want, in case you are ever critically ill and cannot express your own wishes. You can complete a living will. You can also write your wishes down and/or discuss them with your physician or other health care provider and ask him or her to write it down in your chart. You might also want to use written or on-line resources to guide you through this process.



WHAT DO I DO WITH THIS FORM ONCE I COMPLETE IT?

Follow these instructions after you have completed the form:

- a) Sign the form in front of a witness. See the form for a list of who can and cannot witness it.
- b) Ask the witness to sign it, too.
- c) There is no need to have the form notarized.
- d) Give a copy to your agent and to each of your successor agents.
- e) Give another copy to your physician.
- f) Take a copy with you when you go to the hospital.
- g) Show it to your family and friends and others who care for you.

WHAT IF I CHANGE MY MIND?

You may change your mind at any time. If you do, tell someone who is at least 18 years old that you have changed your mind, and/or destroy your document and any copies. If you wish, fill out a new form and make sure everyone you gave the old form to has a copy of the new one, including, but not limited to, your agents and your physicians.

WHAT IF I DO NOT WANT TO USE THIS FORM?

In the event you do not want to use this particular form, any document you complete must be executed by you, designate an agent who is over 18 years of age and not prohibited from serving as your agent, and state the agent's powers, but it need not be witnessed or conform in any other respect to the statutory health care power.

If you have questions about the use of any form, you may want to consult your physicians, other health care provider, and/or an attorney.

MY POWER OF ATTORNEY FOR HEALTH CARE

THIS POWER OF ATTORNEY REVOKES ALL PREVIOUS POWERS OF ATTORNEY FOR HEALTH CARE. (You must sign this form and a witness must also sign it before it is valid.)

Name: (print full name) _____

Address: _____

I WANT THE FOLLOWING PERSON TO BE MY HEALTH CARE AGENT: (an agent is your personal representative under state and federal law):

Agent Name: _____

Agent Address: _____

Agent Phone Number(s): (include all numbers) _____

(Please check box if applicable) If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as guardian.

SUCCESSOR HEALTH CARE AGENT(S) (optional):

If the agent I selected is unable or does not want to make health care decisions for me, then I request the person(s) I name below to be my successor health care agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names):

Successor Agent #1:

Name: _____

Address: _____

Phone Number(s): _____

Successor Agent #2:

Name: _____

Address: _____

Phone Number(s): _____

I AUTHORIZE MY AGENT TO (please check only one box):

_____ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.

OR

_____ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. Starting now, for the purpose of assisting me with my health care plans and decisions, my agent shall have complete access to my medical and mental health records, the authority to share them to others as needed, and the complete ability to communicate with my personal physician(s) and other health care providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself.

OR

_____ Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to. **(If no statement above is checked, then the first statement will be implemented.)**

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes. Your agent will weigh the burdens versus benefits of proposed treatments in make decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements.

SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES (optional):

_____ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.

_____ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

SPECIFIC LIMITATIONS TO MY AGENT’S DECISION-MAKING AUTHORITY:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent’s powers or prescribe special rules or limit the power to authorize autopsy of dispose of remains, you may do so specifically in this form.

Individual Name (print full name): _____

Individual Signature: _____

Date of completed document: _____

HAVE YOUR WITNESS AGREE TO WHAT IS WRITTEN BELOW, AND THEN COMPLETE THE SIGNATURE PORTION:

I am at least 18 years old. (check one of the options below):

_____ I saw the principal sign this document, or

_____ The principal told me that the signature or mark on the principal signature line is his or hers.

I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent or the successor agent(s) by blood, marriage, or adoption. I am not the principal’s physician, advanced practice nurse, primary nurse assigned to patient, dentist, podiatric physician, optometrist, psychologist, or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the health care facility where the principal is a patient or resident.

Witness Name (print name): _____

Witness Address: _____

Witness Signature: _____ Today’s Date: _____

QUESTIONS AND ANSWERS ABOUT LIVING WILLS

1. **What is a Living Will and when does it take effect?**

A Living Will (also called a “declaration”) is a document that you sign that states that you do not want your physician to use death-delaying procedures if you develop a terminal condition. The living will takes effect only if you have a terminal illness and cannot speak for yourself.

2. **What is a “terminal condition”?**

A condition that cannot be cured or reversed, with death imminent, and with the use of death-delaying procedures merely prolonging the dying process.

3. **What is a “death-delaying procedure”?**

Death-delaying procedures serve only to postpone the moment of death. They may include assisted ventilation, artificial kidney treatments, medication, blood transfusions, and tube feeding.

4. **How do I create a Living Will?**

You must be a competent person at least 18 years old. You may fill out and sign the Living Will Declaration contained in this booklet or other forms recognized by Illinois. It must be signed by you, or another person at your direction, in the presence of two *witnesses*.

5. **Who can witness the signing of my Living Will?**

Anyone at least 18 years old who is not entitled to inherit from your estate or financially responsible for your medical care.

6. **When does a Living Will take effect and how long is it effective?**

Your Living Will takes effect when a physician certifies that you have a terminal condition. A living will remains valid until you revoke it.

7. **How do I revoke or change my Living Will?**

A Living Will can be revoked at anytime, regardless of your physical or mental condition, by revoking the current form and signing a new one.

8. **Should I have both a living will and a healthcare power of attorney?**

Your Living Will does not take effect so long as your agent under a healthcare power of attorney is available and willing to make life-sustaining treatment decisions. If you do not wish to be kept alive by life-sustaining treatment, you should consider signing both documents because the living will reinforces the intent of the power of attorney for healthcare.

ILLINOIS LIVING WILL

DECLARATION

I, _____ being of sound mind and lawful age do hereby declare this to be my Living Will which I freely and voluntarily made on this _____ day of _____ (month), 20____ (year). Should I have a prior Living Will, I hereby revoke same and declare this to be my Living Will.

I, willfully and voluntarily, make known my desires that my moment of death shall not be artificially postponed.

If at any time I should have an incurable and irreversible injury, disease, permanent unconsciousness or illness judged to be a terminal condition by my attending physician, who has personally examined me, and my attending physician has determined that my death is imminent, except for death delaying procedures, I direct that procedures which would only prolong the dying process be withheld or withdrawn.

I further direct that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care only.

OTHER DIRECTIONS (IF ANY)

In the absence of my ability to give directions regarding the use of such death delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Should a conflict exist between my Healthcare Power of Attorney form and my Living Will, it is my intention that my HPOA shall be followed as evidence of my preference in this matter.

Signed _____

_____ (Street); _____ (City) _____ (State)

WITNESS DECLARATION

The declarant is personally known to me and I believe him or her to be of sound mind. I saw the declarant sign the Living Will declaration in my presence (or the declarant acknowledged in my presence that he or she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant.

I did not sign the declarant's signature above for or at the direction of the declarant.

At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any Last Will and Testament of declarant or any other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.

Signature

Print Name

Date

Address

Signature

Print Name

Date

Address

[Two witness signatures required.]

WALLET CARDS FOR ILLINOIS ADVANCE DIRECTIVES

Cut out and complete
the cards at the right.
Put one card in the
wallet or purse you carry
most often, along with
your driver's license or
health insurance card.

You can keep the
second card on your
refrigerator, in your
motor vehicle glove
compartment, a spare
wallet or purse, or other
easy-to-find place.



MEMORIAL NETWORK

BJC HealthCare

Memorial Regional Health Services complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.
Llame al 1-618-257-5420 (TTY: 1-800-735-2966).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-618-257-5420 (TTY: 1-800-735-2966)。

HEALTHCARE AGENT / LIVING WILL WALLET IDENTIFICATION CARD

My Name Is: _____

I have signed a Power of Attorney for Healthcare
authorizing my named agent to make my healthcare
decisions for me if I am unable to do so.

My Healthcare Agent Is: _____

His/Her Phone Numbers Are:
(H) _____ (W) _____

My Successor Health care Agent Is:

His/Her Phone Numbers Are:
(H) _____ (W) _____

I have signed a Living Will. If I am suffering from
a terminal condition, a copy may be obtained from:

Name: _____

His/Her Phone Numbers Are:
(H) _____ (W) _____

HEALTHCARE AGENT / LIVING WILL WALLET IDENTIFICATION CARD

My Name Is: _____

I have signed a Power of Attorney for Healthcare
authorizing my named agent to make my health
care decisions for me if I am unable to do so.

My Healthcare Agent Is: _____

His/Her Phone Numbers Are:
(H) _____ (W) _____

My Successor Healthcare Agent Is:

His/Her Phone Numbers Are:
(H) _____ (W) _____

I have signed a Living Will. If I am suffering from
a terminal condition, a copy may be obtained from:

Name: _____

His/Her Phone Numbers Are:
(H) _____ (W) _____