

WYOMING
Advance Directive
Planning for Important Healthcare Decisions

Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org
800/658-8898

CARING CONNECTIONS

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- L**earn about options for end-of-life services and care
- I**mplement plans to ensure wishes are honored
- V**oice decisions to family, friends and healthcare providers
- E**ngage in personal or community efforts to improve end-of-life care

Copyright © 2005 National Hospice and Palliative Care Organization. All rights reserved. Revised 2008. Reproduction and distribution by an organization or organized group without the written permission of the National Hospice and Palliative Care Organization is expressly forbidden.

Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
 - Instructions for preparing your advance directive, please read all the instructions.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

3. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
4. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
5. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
6. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

Introduction to Your Wyoming Advance Health Care Directive

This packet contains a legal document, the Wyoming Advance Health Care Directive, that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

1. Part 1, the **Wyoming Power of Attorney for Health Care**, lets you name someone to make decisions about your healthcare—including decisions about life support—if you can no longer speak for yourself or immediately if you specify this in the document. The Power of Attorney for Health Care is especially useful because it appoints someone to speak for you any time you lack the capacity to make your own healthcare decisions, not only at the end of life. The term capacity means an individual's ability to understand the significant benefits, risks and alternatives to proposed healthcare and to make and communicate a healthcare decision. Your Power of Attorney for Health Care becomes effective when your primary physician or, if your primary physician is unavailable, your supervising physician determines that you lack the capacity to make healthcare decisions.

2. Part 2, the **Wyoming Instructions for Health Care**, functions as your state's living will. It lets you state your wishes about healthcare in the event that you lack the capacity to make your own healthcare decisions, as determined by your primary physician or supervising physician.

3. Part 3, **Donation of Organs at Death**, is an optional section that authorizes the donation of your organs at death.

4. Part 4, **Primary Physician**, is an optional section that allows you to designate your primary physician.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old) or an emancipated minor.

EXPLANATION

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.

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 if 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, 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:

- (a) Consent or refuse to consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;
- (b) Select or discharge health care providers and institutions;
- (c) Approve or disapprove diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and
- (d) 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.

EXPLANATION (CONINUED)

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. 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(s) you have named as agent(s) to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this Advance Health Care Directive or replace this form at any time.

INSTRUCTIONS

PRINT NAME,
ADDRESS AND
TELEPHONE
NUMBERS OF
YOUR PRIMARY
AGENT

PRINT NAME,
ADDRESS AND
TELEPHONE
NUMBERS OF
YOUR FIRST
ALTERNATE AGENT

PRINT NAME,
ADDRESS AND
TELEPHONE
NUMBERS OF
YOUR SECOND
ALTERNATE AGENT

© 2005 National
Hospice and
Palliative Care
Organization.
2008 Revised.

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 and 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 agent)

(address, city, state, zip code)

(home phone and work phone)

OPTIONAL: If I revoke the authority of my agent and first alternative 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 agent)

(address, city, state, zip code)

(home phone and work phone)

ADD PERSONAL INSTRUCTIONS ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT

INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY

CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 3, 4 OR 5 THAT DO NOT REFLECT YOUR WISHES.

© 2005 National Hospice and Palliative Care Organization. 2008 Revised.

(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 or supervising health care provider determines that I lack the capacity to make my own health care decisions unless I initial the following box. If I initial this box [], my agent's authority to make health care decisions for me takes effect immediately.

(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 of the following):*

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

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

(name, address and phone of individual designated as guardian)

(name, address and phone of alternate designated as guardian)

(name, address and phone of second alternate designated as guardian)

[] 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 health care provide, withhold or withdraw treatment in accordance with the choice I have initialed below:

[] (a) Choice Not to Prolong Life – I do not want my life to be prolonged if:

(i) I have an incurable and irreversible condition that will result in my death within a relatively short time,

(ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or

(iii) the likely risks and burdens of treatment would outweigh the expected benefits.

OR

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

INITIAL THE
PARAGRAPH THAT
BEST REFLECTS
YOUR WISHES
REGARDING LIFE-
SUPPORT
MEASURES

© 2005 National
Hospice and
Palliative Care
Organization.
2008 Revised.

INITIAL THE BOX ONLY IF YOU WANT ARTIFICIAL NUTRITION AND HYDRATION REGARDLESS OF YOUR MEDICAL CONDITION

(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 hydration must be provided regardless of my condition and regardless of the choice I have made in paragraph (6).

ADD INSTRUCTIONS, IF ANY

(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:

ADD INSTRUCTIONS (IF ANY)

(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:

(Add additional sheets if needed.)

PART 3: DONATION OF ORGANS AT DEATH (OPTIONAL)

IF YOU DO NOT WISH TO DONATE ORGANS, DO NOT COMPLETE PART 3

(10) UPON MY DEATH *(initial applicable box):*

OTHERWISE INITIAL THE STATEMENTS THAT REFLECT YOUR INTENT AND CROSS OUT ANY STATEMENTS THAT DO NOT REFLECT YOUR INTENT

- [] (a) I give my body; or
- [] (b) I give any needed organs, tissues or parts; or
- [] (c) I give the following organs, tissues or parts only:

(d) My gift is for the following purpose *(strike any of the following you do NOT want)*

- (i) Any purpose authorized by law;
- (ii) Transplantation;
- (iii) Therapy;
- (iv) Research;
- (v) Medical education.

IF YOU DO NOT WANT TO NAME A PRIMARY PHYSICIAN, DO NOT COMPLETE PART 4.

OTHERWISE, PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR PRIMARY PHYSICIAN AND ANY ALTERNATE PRIMARY PHYSICIAN.

SIGN AND DATE THE DOCUMENT IN FRONT OF TWO WITNESSES OR A NOTARY PUBLIC

PRINT YOUR NAME AND ADDRESS

© 2005 National Hospice and Palliative Care Organization. 2008 Revised.

PART 4: PRIMARY PHYSICIAN (OPTIONAL)

(11) PRIMARY PHYSICIAN: I designate the following physician as my primary physician:

(name, address and phone of primary physician)

If the physician I have designated above is not willing, able or reasonably available to act as my primary physician, I designate the following as my primary physician:

(name, address and phone of alternate 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: _____ Date: _____

Print Name: _____

Residence Address: _____

WITNESSING
PROCEDURE FOR
ADVANCE HEALTH
CARE DIRECTIVE

IF YOU USE
WITNESSES, BOTH
WITNESSES MUST
AGREE WITH THIS
STATEMENT. HAVE
YOUR WITNESSES
SIGN AND DATE
THE DOCUMENT
AND PRINT THEIR
NAME AND
ADDRESS

SIGNATURE OF WITNESSES (OPTIONAL)

WITNESS STATEMENT

I declare under penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this document 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 agent by this document, and that I am not a treating health care provider, an employee of a treating health care provider, the operator of a community care facility, an employee of an operator of a community care facility, the operator of a residential care facility or an employee of an operator of a residential care facility.

Witness #1:

Sign: _____ Date: _____

Print Name: _____

Residence Address: _____

Witness #2:

Sign: _____ Date: _____

Print Name: _____

Residence Address: _____

—OR—

SIGNATURE OF NOTARY PUBLIC IN LIEU OF WITNESSES

The State of Wyoming
County of _____

Subscribed, sworn to, and acknowledged before me by

_____, the principal, this

____ day of _____, 20____.

(SEAL) _____

—OR—

IF YOU USE A
NOTARY PUBLIC,
THE NOTARY
PUBLIC SHOULD
FILL OUT THIS
SECTION

© 2005 National
Hospice and
Palliative Care
Organization.
2008 Revised.

*Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898*

You Have Filled Out Your Advance Directive, Now What?

1. Your Wyoming Advance Healthcare Directive is an important legal document. Keep the original signed documents in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.
2. Give photocopies of the signed original to your agent and successor agent(s), doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your agent and successor agent(s), doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your document after it has been signed and witnessed, you must complete a new document.
5. Remember, you can always revoke your Wyoming Advance Healthcare Directive. If you revoke your document, make sure you notify your agent, successor agent(s), your family and your doctors.
6. Be aware that your Wyoming document will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless a person's CPR directive is apparent and immediately available or they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**