

ILLINOIS Advance Directive Planning for Important Health Care Decisions

Caring Connections

1731 King St., Suite 100, Alexandria, VA 22314

www.caringinfo.org

800/658-8898

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.

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 health care providers
- E**ngage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While Caring Connections updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

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Using These Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.
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

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.
2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.
3. 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.
4. 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, health care providers and/or faith leaders so that the form is available in the event of an emergency.
5. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR ILLINOIS ADVANCE DIRECTIVE

This packet contains two legal documents that protect 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.

The **Illinois Power of Attorney for Health Care** lets you name someone — your agent — to make decisions about your medical care if you can no longer speak for yourself. The form lets you set down your wishes regarding organ donation, life-sustaining treatment, burial arrangements, and other advance-planning issues to help your agent make these decisions.

The power of attorney for health care is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Your power of attorney for health care goes into effect when your doctor determines that you are no longer able to make or communicate your health care decisions.

This form does not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Following the Illinois Power of Attorney for Health Care is an **Illinois Living Will**. This document allows you to direct that, if you are suffering from a terminal condition, death-delaying procedures will not be utilized to prolong your life. The Illinois Living Will is limited to this instruction and is not effective if you have an effective power of attorney for health care. The Illinois Living Will is useful if you do not want to name an agent and you want to avoid prolonging your life in the event you have a terminal condition.

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

COMPLETING YOUR ILLINOIS POWER OF ATTORNEY FOR HEALTH CARE AND ILLINOIS LIVING WILL

How do I make my Illinois Power of Attorney for Health Care and my Illinois Living Will legal?

The Illinois Statutory Short Form, on which the following power of attorney for health care form is based, requires that your signature be witnessed by one adult, 18 years of age or older. Your witness cannot be:

- Your attending physician or mental health service provider or a relative of either;
- An owner, operator, or relative of an owner or operator of a health care facility in which you are a patient or resident;
- Your parent, sibling, descendant, or any of their spouses;
- Your agent's parent, sibling, or descendant, or any of their spouses; or
- Your agent or successor agent.

The Illinois statutory living will form, on which the following living will form is based, requires that your signature be witnessed by two adults, 18 years of age or older. The witnesses cannot be a person signing on your behalf, directly financially responsible for your medical care, or entitled to any portion of your estate. As noted above, an Illinois Living Will is not effective if you have a valid Illinois Power of Attorney for Health Care in place.

Note: You do not need to notarize your power of attorney for health care or your living will.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

You can appoint a second and third person as your successor agents. The successor agents will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

Your agent may not be your attending physician or any other health-care provider who is administering health care to you at the time you execute this document.

COMPLETING YOUR ILLINOIS POWER OF ATTORNEY FOR HEALTH CARE AND ILLINOIS LIVING WILL (continued)

Should I add personal instructions to my Illinois Power of Attorney for Health care?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

What if I change my mind?

You may revoke your Illinois power of attorney for health care or your Illinois living will at any time by:

- obliterating, burning, tearing, or otherwise destroying or defacing your document,
- signing and dating a written revocation, or directing another to do so for you, or
- expressing your intent, orally or otherwise, to revoke the document in the presence of a witness 18 years of age or older, who must sign and date a written confirmation that you expressed your intent to revoke.

Revocation of your living will is not effective until it is communicated to your attending physician.

You also may amend your power of attorney for health care at any time by a written amendment signed and dated by you or another person acting at your direction.

What else should I know?

Page 7 of the Illinois Statutory Short Form Power of Attorney allows you to make the choice to discontinue life-sustaining treatment in the event you are in a state of "permanent unconsciousness" or suffer from an "incurable or irreversible condition" or a "terminal condition" as defined by the Illinois Power of Attorney Act. The legal definitions of these terms are below:

"Permanent unconsciousness" means a condition that, to a high degree of medical certainty, (i) will last permanently, without improvement, (ii) in which thought, sensation, purposeful action, social interaction, and awareness of self and environment are absent, and (iii) for which initiating or continuing life-sustaining treatment, in light of the patient's medical condition, provides only minimal medical benefit. For the purposes of this definition, "medical benefit" means a chance to cure or reverse a condition.

COMPLETING YOUR ILLINOIS POWER OF ATTORNEY FOR HEALTH CARE AND ILLINOIS LIVING WILL (continued)

"Incurable or irreversible condition" means an illness or injury (i) for which there is no reasonable prospect of cure or recovery, (ii) that ultimately will cause the patient's death even if life-sustaining treatment is initiated or continued, (iii) that imposes severe pain or otherwise imposes an inhumane burden on the patient, or (iv) for which initiating or continuing life-sustaining treatment, in light of the patient's medical condition, provides only minimal medical benefit.

"Terminal condition" means an illness or injury for which there is no reasonable prospect of cure or recovery, death is imminent, and the application of life-sustaining treatment would only prolong the dying process.

The Illinois legislature has provided explanatory notes throughout the Statutory Short Form Power of Attorney. These notes are presented in this form in *ALL CAPITAL ITALIC LETTERS*.

**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR
HEALTH CARE – PAGE 1 OF 12**

PLEASE READ THIS NOTICE CAREFULLY.

STATUTORY NOTICE

The form that you will be signing is a legal document. It is governed by the Illinois Power of Attorney Act. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.

The purpose of this Power of Attorney is to give your designated "agent" broad powers to make health care decisions for you, including the power to require, consent to, or withdraw treatment for any physical or mental condition, and to admit you or discharge you from any hospital, home, or other institution. You may name successor agents under this form, but you may not name co-agents.

This form does not impose a duty upon your agent to make such health care decisions, so it is important that you select an agent who will agree to do this for you and who will make those decisions as you would wish. It is also important to select an agent whom you trust, since you are giving that agent control over your medical decision making, including end-of-life decisions. Any agent who does act for you has a duty to act in good faith for your benefit and to use due care, competence, and diligence. He or she must also act in accordance with the law and with the statements in this form. Your agent must keep a record of all significant actions taken as your agent.

Unless you specifically limit the period of time that this Power of Attorney will be in effect, your agent may exercise the powers given to him or her throughout your lifetime, even after you become disabled. A court, however, can take away the powers of your agent if it finds that the agent is not acting properly. You may also revoke this Power of Attorney if you wish.

**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR
HEALTH CARE – PAGE 2 OF 12**

STATUTORY NOTICE
(CONTINUED)

The Powers you give your agent, your right to revoke those powers, and the penalties for violating the law are explained more fully in Sections 4-5, 4-6, and 4-10(b) of the Illinois Power of Attorney Act. This form is a part of that law. The "NOTE" paragraphs throughout this form are instructions.

You are not required to sign this Power of Attorney, but it will not take effect without your signature. You should not sign it if you do not understand everything in it, and what your agent will be able to do if you do sign it.

Please put your initials on the following line indicating that you have read this Notice:

PLACE YOUR
INITIALS ON THE
LINE TO INDICATE
THAT YOU HAVE
READ THE NOTICE

(Principal's initials)

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INSTRUCTIONS

ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE — PAGE 3 OF 12

PRINT THE DATE

ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE

POWER OF ATTORNEY made this _____ day of _____.
(day) (month, year)

PRINT YOUR NAME AND ADDRESS

1. I, _____
(name)

(address)

PRINT THE NAME AND ADDRESS OF YOUR AGENT

Hereby revoke all prior powers of attorney for health care executed by me

and appoint: _____
(name of agent)

(address)

as my attorney-in-fact (my "agent") to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization, and health care and to require, withhold, or withdraw any type of medical treatment or procedure, even though my death may ensue.

(NOTE: YOU MAY NOT NAME CO-AGENTS USING THIS FORM.)

A. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others.

B. Effective upon my death, my agent has the full power to make an anatomical gift of the following:

_____ Any organ, tissues, or eyes suitable for transplantation or used for research or education.

_____ Specific organs and/or tissues:

_____ I do not grant my agent authority to make any anatomical gifts.

(NOTE: INITIAL ONE. IN THE EVENT NONE OF THE OPTIONS ARE INITIALED, THEN IT SHALL BE CONCLUDED THAT YOU DO NOT WISH TO GRANT YOUR AGENT ANY SUCH AUTHORITY.)

ANATOMICAL GIFT (OPTIONAL)

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HEALTH CARE — PAGE 4 OF 12**

C. My agent shall also have full power to authorize an autopsy and direct the disposition of my remains. I intend for this power of attorney to be in substantial compliance with Section 10 of the Disposition of Remains Act. All decisions made by my agent with respect to the disposition of my remains, including cremation, shall be binding. I hereby direct any cemetery organization, business operating a crematory or columbarium or both, funeral director or embalmer, or funeral establishment who receives a copy of this document to act under it.

D. I intend for the person named as my agent to be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records, including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder. I intend for the person named as my agent to serve as my "personal representative" as that term is defined under HIPAA and regulations thereunder.

(i) The person named as my agent shall have the power to authorize the release of information governed by HIPAA to third parties.

(ii) I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health care provider, any insurance company and the Medical Informational Bureau, Inc., or any other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment for me for such services to give, disclose, and release to the person named as my agent, without restriction, all of my individually identifiable health information and medical records, regarding any past, present, or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, drug or alcohol abuse, and mental illness (including records or communications governed by the Mental Health and Developmental Disabilities Confidentiality Act).

(iii) The authority given to the person named as my agent shall supersede any prior agreement that I may have with my health care providers to restrict access to, or disclosure of, my individually identifiable health information. The authority given to the person named as my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider. The authority given to the person named as my agent to serve as my "personal representative" as defined under HIPAA and regulations thereunder and to

POWERS OF YOUR
AGENT
(CONTINUED)

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**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR
HEALTH CARE — PAGE 5 OF 12**

access my individually identifiable health information or authorize the release of the same to third parties shall take effect immediately, even if I designate in Paragraph 3 of this document that this agency shall otherwise take effect at some future date.

POWERS OF YOUR
AGENT
(CONTINUED)

(NOTE: 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, INCLUDING WITHDRAWAL OF FOOD AND WATER AND OTHER LIFE-SUSTAINING MEASURES, IF YOUR AGENT BELIEVES SUCH ACTION WOULD BE CONSISTENT WITH YOUR INTENT AND DESIRES. IF YOU WISH TO LIMIT THE SCOPE OF YOUR AGENT'S POWERS OR PRESCRIBE SPECIAL RULES OR LIMIT THE POWER TO MAKE AN ANATOMICAL GIFT, AUTHORIZE AUTOPSY OR DISPOSE OF REMAINS, YOU MAY DO SO IN THE FOLLOWING PARAGRAPHS.)

ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR
HEALTH CARE — PAGE 7 OF 12

(NOTE: THE SUBJECT OF LIFE-SUSTAINING TREATMENT IS OF PARTICULAR IMPORTANCE. FOR YOUR CONVENIENCE IN DEALING WITH THAT SUBJECT, SOME GENERAL STATEMENTS CONCERNING THE WITHHOLDING OR REMOVAL OF LIFE-SUSTAINING TREATMENT ARE SET FORTH BELOW. IF YOU AGREE WITH ONE OF THESE STATEMENTS, YOU MAY INITIAL THAT STATEMENT; BUT DO NOT INITIAL MORE THAN ONE. THESE STATEMENTS SERVE AS GUIDANCE FOR YOUR AGENT, WHO SHALL GIVE CAREFUL CONSIDERATION TO THE STATEMENT YOU INITIAL WHEN ENGAGING IN HEALTH CARE DECISION-MAKING ON YOUR BEHALF.)

LIFE SUSTAINING
TREATMENT
OPTIONS

INITIAL ONLY ONE

I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment.

Initialed _____

I want my life to be prolonged and I want life-sustaining treatment to be provided or continued, unless I am in the opinion of my attending physician, in accordance with reasonable medical standards at the time of reference, in a state of "permanent unconsciousness" or suffer from an "incurable or irreversible condition" or "terminal condition," as those terms are defined in Section 4-4 of the Illinois Power of Attorney Act. If and when I am in any one of the states or conditions, I want life-sustaining treatment to be withheld or discontinued.

Initialed _____

I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards without regard to my condition, the chances I have for recovery or the cost of the procedures.

Initialed _____

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HEALTH CARE — PAGE 8 OF 12

(NOTE: THIS POWER OF ATTORNEY MAY BE AMENDED OR REVOKED BY YOU IN THE MANNER PROVIDED IN SECTION 4-6 OF THE ILLINOIS POWER OF ATTORNEY ACT. YOUR AGENT CAN ACT IMMEDIATELY, UNLESS YOU SPECIFY OTHERWISE; BUT YOU CANNOT SPECIFY OTHERWISE WITH RESPECT TO YOUR "PERSONAL REPRESENTATIVE" UNDER SUBPARAGRAPH D(iii).)

3. This power of attorney shall become effective on _____

(NOTE: INSERT A FUTURE DATE OR EVENT DURING YOUR LIFETIME, SUCH AS A COURT DETERMINATION OF YOUR DISABILITY OR A WRITTEN DETERMINATION BY YOUR PHYSICIAN THAT YOU ARE INCAPACITATED, WHEN YOU WANT THIS POWER TO FIRST TAKE EFFECT.)

(NOTE: IF YOU DO NOT AMEND OR REVOKE THIS POWER, OR IF YOU DO NOT SPECIFY A SPECIFIC ENDING DATE IN PARAGRAPH 4, IT WILL REMAIN IN EFFECT UNTIL YOUR DEATH; EXCEPT THAT YOUR AGENT WILL STILL HAVE THE AUTHORITY TO DONATE YOUR ORGANS, AUTHORIZE AN AUTOPSY, AND DISPOSE OF YOUR REMAINS AFTER YOUR DEATH, IF YOU GRANT THAT AUTHORITY TO YOUR AGENT.)

4. This power of attorney shall terminate on _____

(NOTE: INSERT A FUTURE DATE OR EVENT, SUCH AS A COURT DETERMINATION THAT YOU ARE NOT UNDER A LEGAL DISABILITY OR A WRITTEN DETERMINATION BY YOUR PHYSICIAN THAT YOU ARE NOT INCAPACITATED, IF YOU WANT THIS POWER TO TERMINATE PRIOR TO YOUR DEATH.)

PRINT EFFECTIVE
DATE OR EVENT
(OPTIONAL)

PRINT EXPIRATION
DATE OR EVENT
(OPTIONAL)

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**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR
HEALTH CARE — PAGE 9 OF 12**

(NOTE: YOU CANNOT USE THIS FORM TO NAME CO-AGENTS. IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAMES AND ADDRESSES OF THE SUCCESSORS IN PARAGRAPH 5.)

5. If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent:

1. Name _____

Address _____

Phone _____

2. Name _____

Address _____

Phone _____

For purposes of this paragraph 5, a person shall be considered to be incompetent if and while the person is a minor or an adjudicated incompetent or disabled person or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.

FIRST SUCCESSOR
AGENT

SECOND
SUCCESSOR
AGENT

**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR
HEALTH CARE — PAGE 11 OF 12**

8. I am fully informed as to all the contents of this form and understand the full importance of this grant of powers to my agent.

SIGN AND DATE
YOUR DOCUMENT
HERE

(Principal's Signature or Mark)

(Date)

The principal has had an opportunity to review the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence. The undersigned witness certifies that the witness is not: (a) the attending physician or mental health service provider or a relative of the physician or provider; (b) an owner, operator, or relative of an owner or operator of a health care facility in which the principal is a patient or resident; (c) a parent, sibling, descendant, or any spouse of such parent, sibling, or descendant of either the principal or any agent or successor agent under the foregoing power of attorney, whether such relationship is by blood, marriage, or adoption; or (d) an agent or successor agent under the foregoing power of attorney.

(Witness Signature)

(Date)

YOUR WITNESS
SIGNS AND DATES
HERE

(Print Witness Name)

(Street Address)

(City, State, Zip)

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ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR
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(NOTE: YOU MAY, BUT ARE NOT REQUIRED TO, REQUEST YOUR AGENT AND SUCCESSOR AGENTS TO PROVIDE SPECIMEN SIGNATURES BELOW. IF YOU INCLUDE SPECIMEN SIGNATURES IN THIS POWER OF ATTORNEY, YOU MUST COMPLETE THE CERTIFICATION OPPOSITE THE SIGNATURES OF THE AGENTS.)

Specimen signatures of agent
(and successors).

I certify that the signatures of my
agent (and successors) are correct.

(agent)

(principal)

(successor agent)

(principal)

(successor agent)

(principal)

(NOTE: THE NAME, ADDRESS, AND PHONE NUMBER OF THE PERSON PREPARING THIS FORM OR WHO ASSISTED THE PRINCIPAL IN COMPLETING THIS FORM IS OPTIONAL.)

(Name of Preparer)

(Street Address)

(City, State, Zip)

(Phone)

PROVIDE
SPECIMEN
SIGNATURES OF
YOUR AGENTS AND
ALTERNATES, IF
DESIRED
YOU MUST SIGN TO
CERTIFY THEIR
SIGNATURES
(OPTIONAL)

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

DECLARATION

This declaration is made this _____ day of _____

(month, year). I, _____ being of sound mind, 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, or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death-delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and 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.

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.

Signed _____

City, County and State of Residence _____

The declarant is personally known to me and I believe him or her to be of sound mind. I saw the declarant sign the 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 will of declarant or other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.

Witness _____

Witness _____

DATE YOUR DOCUMENT HERE

SIGN HERE

PRINT YOUR ADDRESS HERE

TWO WITNESSES MUST SIGN

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You Have Filled Out Your Health Care Directive, Now What?

1. Your Illinois durable power of attorney for health care and Illinois living will are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your agent and alternate agent, doctor(s), family, close friends, clergy and anyone else who might become involved in your health care. 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(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.
5. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.
6. Remember, you can always revoke your Illinois documents.
7. Be aware that your Illinois documents will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency 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 if you are interested in obtaining this form.

Caring Connections does not distribute these forms.