Rhode Island Durable Power Of Attorney For Health Care

AN ADVANCE CARE DIRECTIVE

"A GIFT OF PREPAREDNESS"

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(RHODE ISLAND HEALTH CARE ADVANCE DIRECTIVE)

I, _____,
(Insert your name and address)
am at least eighteen (18) years old, a resident of the State of Rhode Island, and understand this document allows me to name another person (called the health care agent) to make health care decisions for me if I can no longer make decisions for myself and I cannot inform my health care providers and agent about my wishes for medical treatment.

PART I: APPOINTMENT OF HEALTH CARE AGENT
THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS FOR ME IF I CAN NO LONGER MAKE DECISIONS

Note: You may not appoint the following individuals as an agent:

(1) your treating health care provider, such as a doctor, nurse, hospital, or nursing home,
(2) a nonrelative employee of your treating health care provider,
(3) an operator of a community care facility, or
(4) a nonrelative employee of an operator of a community care facility.

When I am no longer able to make decisions for myself, I name and appoint _____ to make health care decisions for me. This person is called my health care agent.

Telephone number of my health care agent: _____
Address of my health care agent: _____
_____

You should discuss this health care directive with your agent and give your agent a copy.

(OPTIONAL)
APPOINTMENT OF ALTERNATE HEALTH CARE AGENTS:

You are not required to name alternative health care agents. An alternative health care agent will be able to make the same health care decisions as the health care agent named above, if the health care agent is unable or ineligible to make health care decisions for you. For example, if you name your spouse as your health care agent and your marriage is dissolved, then your former spouse is ineligible to be your health care agent.

When I am no longer able to make decisions for myself and my health care agent is not available, not able, loses the mental capacity to make health care decisions for me, becomes ineligible to act as my agent, is not willing to make health care decisions for me, or I revoke the person appointed as my agent to make health care decisions for me, I name and appoint the following persons as my agent to make health care decision for me as authorized by this document, in the order listed below:

_____ **My Initials**

PART II: HEALTH CARE INSTRUCTIONS

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

Many medical treatments may be used to try to improve my medical condition in certain circumstances or to prolong my life in other circumstances. Many medical treatments can be started and then stopped if they do not help. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start the heart, surgeries, dialysis, antibiotics, and blood transfusions. The back inside page has more information about life-support measures.

OPTIONAL -FOR DISCUSSION PURPOSES

A discussion of these questions with your health care agent may help him or her make health care decisions for you which reflect your values when you cannot make those decisions.

These are my views which may help my agent make health care decisions:

1. Do you think your life should be preserved for as long as possible? Why or why not?

_____
_____
_____

2. Would you want your pain managed, even if it makes you less alert or shortens your life?

_____
_____
_____

3. Do your religious beliefs affect the way you feel about death? Would you prefer to be buried or cremated?

_____
_____
_____

4. Should financial considerations be important when making a decision about medical care?

_____
_____
_____

5. Have you talked with your agent, alternative agent, family and friends about these issues?

_____
_____
_____

_____ **My Initials**

RELIGIOUS AND SPIRITUAL REQUESTS

Do you want your Rabbi, Priest, Clergy, Minister, Imam, Monk, or other spiritual advisor contacted if you become sick?

INITIAL ONLY ONE:
_____ Yes _____ No

Name of Rabbi, Priest, Clergy, Minister, Imam, Monk, or other spiritual advisor:

_____

Address: _____

Phone Number: _____

DURATION

Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.

I do not want this durable power of attorney for health care to exist until revoked. I want this durable power of attorney for health care to expire on _____
(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)

REVOCATION

I can revoke this Durable Power of Attorney for Health Care at any time and for any reason either in writing or orally. If I change my agent or alternative agents or make any other changes, I need to complete a new Durable Power of Attorney for Health Care with those changes.

PART III: MAKING THE DOCUMENT LEGAL

I revoke any prior designations, advance directives, or durable power of attorney for health care.

Date and Signature of Principal

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

_____

Signature Date signed:

_____ **My Initials**

Two Qualified Witnesses or One Notary Public Declaration

At least one of the qualified witnesses or the notary public must make this additional declaration:

I further declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

Print Name: _____

Signature: _____

Print Name: _____

Part IV: Distributing The Document

You are not required to give anyone your Durable Power of Attorney for Health Care, but if it cannot be found at the time you need it, it cannot help you. For example, you are unable to participate in making health care decisions and your Durable Power of Attorney for Health Care is a safe deposit box, the agent, physician and other health care providers will not have access to it and they will not be able to respect your medical treatment wishes. You may want to give a copy of your Durable Power of Attorney for Health Care to some or all of the persons listed below so that it can be available when you need it.

(Name) (Address) (Phone)

❑ Health Care Agent

_____

❑ First Alternative Health Care Agent

_____

❑ Second Alternative Health Care Agent

_____

❑ Physician

_____

❑ Family

_____

❑ Lawyer

_____

❑ Others

_____

Commonly Used Life-Support Measures

Cardiopulmonary Resuscitation (CPR)

Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

When used quickly in response to a sudden event like a heart attack or drowning, CPR can be life-saving. But the success rate is extremely low for people who are at the end of a terminal disease process. Critically ill patients who receive CPR have a small chance of recovering or leaving the hospital.

Rhode Islanders with a terminal condition who do not want rescue/ambulance service/emergency medical services personnel to perform CPR may join COMFORT ONE. Rescue/ambulance/emergency workers will provide comfort measures but will not perform CPR or any resuscitation. To join COMFORT ONE, speak to your physician. ONLY your physician can enroll you in the COMFORT ONE PROGRAM. Your physician writes a medical order directing rescue/ambulances service/emergency personnel not to start CPR which is filed with the Rhode Island Department of Health.

Mechanical Ventilation

Mechanical ventilation is used to help or replace how the lungs work. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea). Mechanical ventilation often is used to assist a person through a short-term problem or for prolonged periods in which irreversible respiratory failure happens due to injuries to the upper spinal cord or a progressive neurological disease.

Some people on long-term mechanical ventilation are able to enjoy themselves and live a quality of life that is important to them. For the dying patient, however, mechanical ventilation often merely prolongs the dying process until some other body system fails. It may supply oxygen, but it cannot improve the underlying condition.

When discussing end-of-life wishes, make clear to loved ones and your physician whether you would want mechanical ventilation if you would never regain the ability to breathe on your own or return to a quality of life acceptable to you.

Artificial Nutrition and Hydration

Artificial nutrition and hydration (or tube feeding) supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluid through a tube placed directly into the stomach, the upper intestine, or a vein. Artificial nutrition and hydration can save lives when used until the body heals.

Long-term artificial nutrition and hydration may be given to people with serious intestinal disorders that impair their ability to digest food, thereby helping them to enjoy a quality of life that is important to them. Sometimes long-term use of tube feeding frequently is given to people with irreversible and end-stage conditions which will not reverse the course of the disease itself or improve the quality of life. Some health care facilities and physicians may not agree with stopping or withdrawing tube feeding. You may want to talk with your loved ones and physician about your wishes for artificial nutrition and hydration in your Durable Power of Attorney for Health Care.

HIPAA PERMITS DISCLOSURE OF MOLST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY.
MOLST IS VOLUNTARY. NO PATIENT IS REQUIRED TO COMPLETE A MOLST FORM.

Medical Orders for Life Sustaining Treatment (MOLST)

Follow these orders, then contact a MOLST-Qualified Health Care Provider. This is a **Medical Order Sheet** based upon the person's wishes in his/her current medical condition. Any section not completed implies full treatment. **This MOLST remains in effect unless revised.**

Patient's Last Name _____ Patient's First Name _____

Gender: ☐ M ☐ F Patient's Date of Birth / / Date/Time Form Prepared _____

A — CHECK ONE

CARDIOPULMONARY RESUSCITATION (CPR): *Person has no pulse and is not breathing.*

☐ **Attempt Resuscitation/CPR** ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

- No defibrillator (including automated external defibrillators) should be used on a person who has chosen "Do Not Attempt Resuscitation."
- When not in cardiopulmonary arrest, follow orders in sections B and C.

B* — CHECK ONE

MEDICAL INTERVENTION: *Patient has a pulse and/or is breathing.*

☐ **Comfort Measures Only:** Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Use antibiotics only to promote comfort.

☐ **Limited Additional Interventions:** Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.

☐ **Full Treatment:** Includes care described above in Comfort Measures Only and Limited Additional Interventions, as well as additional treatment, such as intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated.

C — CHECK ONE

TRANSFER TO HOSPITAL

☐ Do not transfer to hospital for medical interventions. ☐ Transfer to hospital if comfort measures cannot be met in current location.

D — CHECK ONE

ARTIFICIAL NUTRITION (For example a feeding tube): *Offer food by mouth if feasible and desired.*

☐ No artificial nutrition ☐ Defined trial period of artificial nutrition
☐ Long-term artificial nutrition, if needed ☐ Artificial nutrition until not beneficial or burden to patient

E — CHECK ONE

ARTIFICIAL HYDRATION: *Offer fluid/nutrients by mouth if feasible and desired.*

☐ No artificial hydration ☐ Defined trial period of artificial hydration
☐ Long-term artificial hydration, if needed ☐ Artificial hydration until not beneficial or burden to patient

F

ADVANCE DIRECTIVE (if any): *Check all advance directives known to be completed.*

☐ Durable Power of Health Care ☐ Health Care Proxy ☐ Living Will ☐ Documentation of Oral Advance Directive

Discussed with:

☐ Patient ☐ Health Care Decision Maker ☐ Parent/Guardian of Minor ☐ Court-Appointed Guardian ☐ Other: _____

G

SIGNATURE OF MOLST-QUALIFIED HEALTHCARE PROVIDER (Physician, RNP, APRN, or PA)

My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.

Signature (required) _____ Phone Number _____ Date/Time / /

Print Name _____ Rhode Island License # _____

SIGNATURE OF PATIENT, DECISION MAKER, PARENT/GUARDIAN OF MINOR, OR GUARDIAN

By signing this form, the patient or legally-recognized decision maker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Signature (Required) _____ Phone Number _____ Relationship (if patient, write self) _____

Print Name and Address _____

SEND MOLST FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED.