11th and Broadway
Quincy, IL 62301
(217) 223-1200

640 W. Washington St.
Pittsfield, IL 62363
(217) 285-2113

06/23/14
Rev. 02/2015
Rev. 09/2015
Rev. 10/2018

BLESSING
Health System

ADVANCE DIRECTIVES

Are they for me?

blessinghealth.org

ADDITIONAL INFORMATION

Declaration for Mental Health Treatment

Because the symptoms of a mental disorder might make you unable to express your true wishes about mental health treatment, you can specify in advance your preference for mental health treatment in a Declaration for Mental Health Treatment. The Declaration allows you to name the specific symptoms for which you would want or not want mental health treatment. Treatments covered by the Declaration include psychotropic medication, electroconvulsive treatment (ECT) and admission to and retention in a mental health treatment facility. You can also appoint an individual to make decisions about your mental health treatment if you are unable to do so. Blessing Health System makes these forms available in a separate brochure available upon request. For information on the Declaration for Mental Health Treatment, call John McDowell, Blessing Inpatient Behavioral Health, 217-223-8400, ext. 4532.

The Illinois Health Care Surrogate Act

When there is no Living Will or Durable Power of Attorney for Healthcare this law allows family members (and others) to make healthcare decisions on behalf of a patient who is not able to make decisions for his/herself. The Act outlines a formal order in which persons may serve as surrogate decision-makers. It also describes the particular circumstances that must exist for making different types of treatment decisions. More information about this Act can be obtained by contacting Inpatient Care Coordination, (217) 223-8400, ext. 7900.

Illinois Department of Public Health Uniform Practitioner Orders for Life-Sustaining Treatment (P.O.L.S.T.) form

The POLST form allows you, in consultation with your physician, to make an advance decision regarding the cardiopulmonary resuscitation (CPR) you want attempted if your heart and/or breathing stops. Other treatments and measures to promote your comfort and dignity will continue to be provided. CPR refers to various medical procedures used in an effort to restart a person's heart and/or breathing. In the absence of a DNR order, healthcare professionals will automatically begin CPR when an individual's heartbeat and/or breathing stop.

Additional information on Illinois's POLST is available at http://polstil.org or by calling Inpatient Care Coordination, (217) 223-8400, ext. 7900.

Cut along dotted line and keep in your wallet.

Date: _____

Name: _____

I have:
- ☐ Power of Attorney for Healthcare
- ☐ Living Will
- ☐ Mental Health Treatment Declaration
- ☐ P.O.L.S.T.

My advance directive is on file at:

_____

My agent is: _____

Phone: _____

Signed: _____

HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

IDPH POLST ■ IDPH POLST ■ IDPH POLST ■ IDPH POLST ■ IDPH POLST ■ IDPH POLST

****THIS SIDE FOR INFORMATIONAL PURPOSES ONLY****

Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

❑ Health Care Power of Attorney ❑ Living Will Declaration ❑ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	**Date Prepared**

Completing the IDPH POLST Form

- **The completion of a POLST form is always voluntary, cannot be mandated and may be changed at any time.**
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g. ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at
http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

IOCI 17-564

Page 2

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2017

ADVANCE DIRECTIVES

Are they for me?

If you are unable to make decisions for yourself because of an accident or illness, would those persons caring for you know how to treat you? Would your family and your doctors know how you would want decisions made about your care? A document which names a person you wish to make healthcare decisions for you anytime you are not able to speak for yourself is known as a durable power of attorney for healthcare. A living will is a written document in which you can outline the kind of treatment you want for yourself at the end of your life. You do not need both documents. However, if you decide only to do one, the durable power of attorney for healthcare is preferred because the authority you grant your agent to act on your behalf is greater and you do not have to be terminally ill/dying for it to be active.

If you have questions regarding any information in this booklet, contact Inpatient Care Coordination at (217) 223-8400, ext. 7900.

HIPAA PERMITS DISCLOSURE OF POLST TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

State of Illinois
Illinois Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)	Gender ❑ M ❑ F	
Address (street/city/state/ZIPcode)		

A — CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

Check One

❑ **Attempt Resuscitation/CPR** ❑ **Do Not Attempt Resuscitation/DNR**

(*Selecting CPR means* **Full Treatment** *in Section B is selected*)

When not in cardiopulmonary arrest, follow orders B and C.

B — MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.

Check One (optional)

❑ **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*

❑ **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*

❑ **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Optional Additional Orders _____

C — MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired.

Check One (optional)

❑ Long-term medically administered nutrition, including feeding tubes.

❑ Trial period of medically administered nutrition, including feeding tubes.

❑ No medically administered means of nutrition, including feeding tubes.

Additional Instructions (e.g., length of trial period)

_____

_____

D — DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

❑ Patient ❑ Agent under health care power of attorney

❑ Parent of minor ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature ***(required)***	Name (print)	Date

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature ***(required)***	Name (print)	Date

E — Signature of Authorized Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

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

Print Authorized Practitioner Name ***(required)***	Phone ( ) _____ - _____
Authorized Practitioner Signature ***(required)***	Date ***(required)***

Form Revision Date - May 2017 **(Prior form versions are also valid.)**

SEND A COPY OF FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED • COPY ON ANY COLOR OF PAPER IS ACCEPTABLE • 2017

IDPH POLST

Durable Power of Attorney for Healthcare (DPOAHC):

- In addition to providing a way to record specific wishes you may have about medical treatments, this document allows you to name another person (proxy or agent) who can speak for you and make healthcare decisions for you if you are unable to speak for yourself or if you choose someone to make decisions for you now and continue when you can no longer make your own decisions.
- The agent has the authority to act on your behalf anytime you designate. Your condition does not have to be terminal or irreversible.
- The agent has the authority to speak for you and decide on your behalf regarding any healthcare decisions that might need to be made, not just decisions about life-support equipment but including things like consent to invasive procedures, surgery and dialysis.
- You may give the agent specific instructions regarding certain issues or you may chose to limit his or her authority.
- The DPOAHC is the preferred document for recording and communicating your care wishes.

Living Will:

- A Living Will is a way of writing down which medical treatments you do or do not want at the end of your life.
- A Living Will takes effect only when you can no longer express your wishes yourself.
- A Living Will takes effect only if your physician(s) have determined that you suffer from a terminal or incurable, irreversible condition and death is imminent.
- A Living Will generally applies only to treatments that are considered "life-support" or "life-prolonging" or "death delaying" such as the use of a breathing machine.

Practitioner Orders for Life Sustaining Treatment (P.O.L.S.T.)

Illinois is one of several states that have adopted the P.O.L.S.T. form as a way to:

- Help healthcare professionals know and honor the life-sustaining treatment wishes of their patients.
- Promote patient autonomy by creating medical orders that reflect the patient's treatment preferences.
- Facilitate appropriate treatment by emergency medical personnel.
- Provide a portable medical order honored by multiple providers, such as ambulance staff, emergency responders, long term care facilities and hospitals.

Although the P.O.L.S.T. is an Advance Directive, it is not intended to take the place of the DPOAHC. It should be used in combination with other Advance Directives a patient has. The P.O.L.S.T. is a practitioner's order used to communicate your wishes when you are unable to do so.

How do I know what I want?

Although we understand that illness and death are a part of life, talking about what is important can be especially difficult for many families. By thinking about these things ahead of time we can make those times less stressful.

Ask yourself what is most important to you in life. How important is it to you to be physically and/or financially independent? What physical and/or mental limitations could you accept and still find life meaningful and enjoyable? What fears, if any, do you have about injuries or illnesses that might significantly change your life?

Whether or not we belong to an organized religious community, we all have values, beliefs and life goals that guide our thinking about life and death. What do you believe about such issues and the role of suffering and pain (do they have any meaning?) or the prolonging of life when recovery is not possible? You might want to talk with family, close friends or clergy to help you clarify your beliefs about life and the end of life.

This booklet contains a series of statements (page 7) to help you identify what is important to you. Take the time to complete the statements and share the information with your family. It will make it easier for them to try to make the decisions that you would have made if they understand how you feel about these important issues. It also helps physicians and other care team members provide care that is consistent with what you value.

Why do I need an Advance Directive?

Advance Directives give you a voice in decisions about your medical treatment and care when you are no longer able to communicate these. Research shows that most people will die in a hospital or long term care facility where current medical technology can keep people alive longer than in the past; not always at the quality of life than an individual wants. Often families must make difficult decisions for the continued care and treatment of their loved one. This can be emotionally painful and create family conflicts if the person's wishes are not known. When these situations face families, an Advance Directive is a tool to provide your loved ones with guidance in making the decisions for your ongoing care and treatment that you would want. An Advance Directive is a gift only you can give to your family.

LIVING WILL

I, _____ born on _____ wish to make it known to those who may be charged with my care that I desire that the moment of my death not be artificially postponed.

If I should have an incurable and irreversible injury, disease or illness that, in my attending physician's judgment, will lead to my imminent death, I direct that any procedures or treatments that would only prolong my dying be withheld or withdrawn. I ask that I be provided only those treatments that will, in my physician's judgment, contribute to my comfort.

In the event of my inability to personally give direction regarding my care, it is my intention that this statement be honored by my family and my physicians as my legal right to refuse medical or surgical treatment. I understand and accept the consequence of my refusal.

Additional Directives:

_____

_____

_____

Signed _____

City, County and State of residence: _____

Date: _____

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: _____

NAME YOUR SUCCESSOR AGENTS HERE

ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE (LAST PAGE)

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 and phone number)

_____

_____

(Successor agent #2 name, address and phone number)

What is an "Agent"?

Even the most knowledgeable and experienced healthcare worker would be unable to predict all the possible situations we might face in the future. So, even if you have a living will expressing your desires about the treatment you want, you may want to name someone you trust to make healthcare decisions for you when you are unable to do so yourself. A Durable Power of Attorney for Healthcare is a document which allows you to appoint an agent for yourself.

- Your agent's responsibility is to see that your wishes for medical treatment are followed as closely as possible. If your specific wishes about a treatment are not known, it is the agent's duty to use his or her knowledge of you, your wishes, beliefs and values, to decide as they believe you would decide.
- Your agent has the authority to make all healthcare-related decisions including disposition of your body after death. A friend appointed as 'agent' can overrule family wishes.
- You can give your agent specific directions. You can also place specific limitations upon their authority.
- Your agent (under a DPOAHC) has no control over or access to your financial resources and cannot be held responsible for your expenses.

State regulations vary. Most states will honor an advance directive which is legal in the state it was first written. However, if you move to another state, or spend significant time in another state (such as winters) you may want to check on the laws in that state to ensure that your wishes can still be carried out. Missouri and Iowa residents must have their DPOAHC notarized. Notarization is not required for Illinois residents.

Who should I choose?

Serving as healthcare agent for another person is a serious responsibility. Take time to consider who can best serve in this role for you. An agent should be

- At least 18 years of age;
- A family member OR close friend OR another individual you want to speak on your behalf (e.g., minister, priest, rabbi);
- Someone who knows you and your values well and to whom you feel comfortable discussing your wishes regarding healthcare;
- Someone you trust to do what is best for you and who is willing to carry out your wishes, even if they do not agree with your choices;
- Someone who would be comfortable talking with and questioning physicians and others caring for you;
- Someone who can be available when decisions need to be made. (A close friend who lives nearby may be more effective than an adult child who lives thousands of miles away); or
- Someone who is NOT your physician or other personal healthcare provider.

You may wish to consider the naming of alternate or successor agents. In the event your agent is unavailable or unable to make decisions for you, your alternate agent will be able to act on your behalf. You may list more than one alternate; they would serve in the order listed by you. You should not choose two people to serve as your agent at the same time to share the duties of agent.

What will happen if I don't choose an agent for healthcare?

If there is a period of time when you are unable to make medical decisions because you are too sick, Illinois law (Health Care Surrogate Act) dictates who the care team will turn to for help with decision-making. Depending upon your situation, this may or may not work for you. Some reasons it might not be best include 1) the person named by law may not be the person you would pick; 2) the person identified by the law may not know or be able to carry out your wishes; and 3) the person identified may not be able to make all the decisions you might have made because of limitations placed upon them by law (especially with regard to withholding or withdrawing treatments).

What do I do now?

- Complete the attached form(s), or use another form if you wish. If you add additional pages, make sure you sign and date them.
- Sign and date the form in front of a witness and have them sign it too. A list of who can (and cannot) serve as witness is included on the form.
- Make copies of the completed document and give them to your agent (and alternates, if any), your doctor(s), your family and any close friends who might be involved in your care. If you can, carry a copy with you. Make sure that a copy goes with you any time you might be hospitalized.

What if I change my mind?

You can change your mind about your agent or your preferences at any time. Just let someone know (like your agent or care provider) and/or destroy your old documents. If you want to complete another form, remember to give copies to everyone you gave the 'old' form to. Simple changes (like updating phone numbers or addresses) can be done to a pre-existing form; just sign and date the updates.

Anything else?

- Even though you have completed an Advance Directive, be sure you talk with your family and that they understand your wishes.
- Talk with your physician(s). The more they understand your wishes and concerns, the better equipped they will be to treat you as you wish.
- Provide the hospital with a copy of your Advance Directive at the time you use hospital services.
- Contact the Inpatient Care Coordination department (ext. 7900) if you have any more questions or need additional copies.
- If you need information regarding an Advance Directive that is on file within the Blessing Health System, please contact Health Information Management for assistance.
- For information on the Declaration for Mental Health Treatment, call John McDowell, Blessing Inpatient Behavioral Health, 217-223-8400, ext. 4532.
- When this form is completed and properly witnessed it is considered a legal document. Missouri and Iowa residents must have their DPOAHC notarized. Notarization is not required for Illinois residents.

ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE (PAGES 9-12)

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 or dispose of remains, you may do so specifically in this form.

LIST ANY LIMITS TO AGENT'S POWERS

_____

_____

SIGN AND DATE HERE

My signature: _____

Today's date: _____

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):

CHECK ONE OF THE TWO BOXES

☐ 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.

RESTRICTIONS ON WITNESSES

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, mental health service provider, 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.

HAVE WITNESS PRINT NAME AND ADDRESS AND SIGN HERE

Witness printed name: _____

Witness address: _____

Witness signature: _____

Today's date: _____

NOTARY SECTION (NOT required for Illinois) _____

State of _____ County of _____. Before me, the undersigned notary public, this day, personally appeared to me known, who being duly sworn according to law. Subscribed and sworn before me this _____day of _____

_____ _____

Notary Public My Commission expires

ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE (PAGES 9-12)

CHECK ONE OF THE TWO BOXES

YOU MAY CHECK ONE OF THE TWO BOXES, OR YOU MAY DECLINE TO CHECK EITHER

I AUTHORIZE MY AGENT TO (please check any 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. (If no box is checked, then the box above shall be implemented.) 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.

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, in making decisions concerning life-sustaining treatment, 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 making 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.

YOU MIGHT WANT TO USE THE FOLLOWING CHART TO HELP IDENTIFY SOME OF YOUR MOST IMPORTANT VALUES RELATED TO YOUR HEALTH AND HEALTHCARE:

I want to be able to:

	LESS IMPORTANT				VERY IMPORTANT
• care for myself without assistance	1	2	3	4	5
• get out of bed (not bedridden)	1	2	3	4	5
• move about independently	1	2	3	4	5
• recognize family and friends	1	2	3	4	5
• make my own decisions	1	2	3	4	5
• live in my own home	1	2	3	4	5
• be free of chronic, severe pain	1	2	3	4	5
• live without long-term life support like breathing machines, feeding tubes, dialysis	1	2	3	4	5
• be financially independent	1	2	3	4	5
• leave a substantial estate to people or causes important to me	1	2	3	4	5
• live and die in keeping with my beliefs	1	2	3	4	5
•die naturally (without the use of machines or attempts at resusciation)	1	2	3	4	5

Things to Consider: Complications and Conditions

Depending upon your medical condition, there may be many treatment decisions that can be made. Some treatments may extend the length of your life but may not improve its quality. Other treatments have a low likelihood of success and involve a great deal of pain and discomfort as well as cost. There may be treatments that you would agree to in one set of circumstances and not another. You should always feel free to ask your physician about the expected benefits as well as potential risks and burdens of proposed treatments. Some things to consider are:

- Unexpected complications: If treated promptly and aggressively, your chances for a full recovery are usually very good.
- Chronic conditions: Diseases like emphysema, COPD or diabetes can be treated well for many years but eventually even the best care will not be able to control the disease or its symptoms.
- Incurable diseases: Some diseases, like advanced cancer or AIDS, can be treated for a time and your life extended but your condition will worsen over time and the disease will not be cured.
- PVS (persistent/permanent vegetative state) or irreversible comas: Brain damage in these situations is irreversible and treatment is highly unlikely to lead to your regaining consciousness. Ventilators and feeding tubes can keep your heart and lungs working for an extended time but they cannot restore the functioning of your brain.

PRINT YOUR NAME AND ADDRESS

PRINT THE NAME, ADDRESS, AND PHONE NUMBER OF YOUR AGENT

ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE (PAGES 9-12)

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)

My name (Print your full name): _____

My 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) _____

MY AGENT CAN MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING:

(i) Deciding to accept, withdraw or decline treatment for any physical or mental condition of mine, including life-and-death decisions.

(ii) Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.

(iii) Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.

(iv) Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue or whole body donation, autopsy, cremation, and burial.

The above grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures.