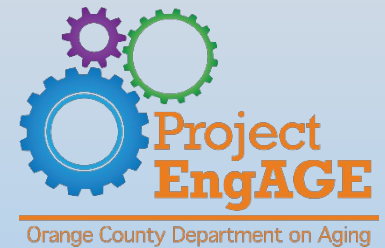


Advance Directive Options

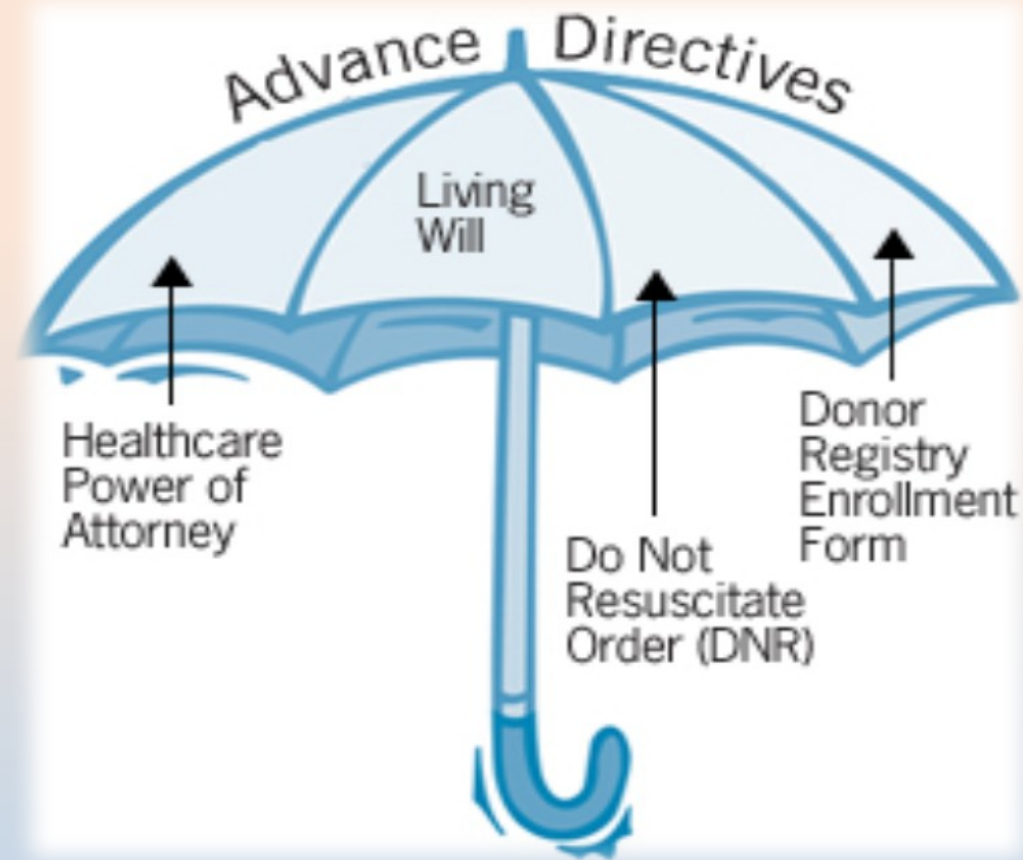
Lydia Arnold, MS Gerontology

Aging Transitions/Volunteer Connect 55+ Specialist

Orange County Department on Aging



Advance Directive = Umbrella Term



Please note: Advance directives do not concern financial planning.

Common

- Living Will
- Health Care Power of Attorney
- NC Practical
- Five Wishes
- DNR

Less Common

- Psychiatric Advance Directive (PAD)
- Supplemental Advance Directive for Dementia
- MOST

What's the Difference?

- **Living Will** – document stating treatment preferences, only valid when individual is unable to communicate wishes.
- **Healthcare Power of Attorney** – document that designates a “health care agent” and their powers.
- **NC Practical Form** – document is a combination of living will + designation of health care agent.
- **Five Wishes** – “easy-to-use” booklet written in everyday language that allows designation of health care agent + more specific end of life wishes.

- **Supplemental Advance Directive for Dementia** – supplements an existing AD if individual chooses VSED at time of “chosen end point” of progressed dementia and has a designated health care agent in agreeance to advocate on individuals behalf.
- **Psychiatric Advance Directive (PAD)** – document stating treatment preferences in the case of a mental health crisis that prevents decisional capacity, also referred to as “Mental Health Advance Directive.”

What's the Difference?

- **Living Will** – document stating treatment preferences, only valid when individual is unable to communicate wishes.

STATE OF NORTH CAROLINA

ADVANCE DIRECTIVE FOR A
NATURAL DEATH ("LIVING WILL")

COUNTY OF _____

NOTE: YOU SHOULD USE THIS DOCUMENT TO GIVE YOUR HEALTH CARE PROVIDERS INSTRUCTIONS TO WITHHOLD OR WITHDRAW LIFE-PROLONGING MEASURES IN CERTAIN SITUATIONS. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A LIVING WILL.

GENERAL INSTRUCTIONS: You can use this Advance Directive ("Living Will") form to give instructions for the future if you want your health care providers to withhold or withdraw life-prolonging measures in certain situations. You should talk to your doctor about what these terms mean. The Living Will states what choices you would have made for yourself if you were able to communicate. Talk to your family members, friends, and others you trust about your choices. Also, it is a good idea to talk with professionals such as your doctors, clergypersons, and lawyers before you complete and sign this Living Will.

You do not have to use this form to give those instructions, but if you create your own Advance Directive you need to be very careful to ensure that it is consistent with North Carolina law.

This Living Will form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. Do not sign this form until two witnesses and a notary public are present to watch you sign it. You then should consider giving a copy to your primary physician and/or a trusted relative, and should consider filing it with the Advanced Health Care Directive Registry maintained by the North Carolina Secretary of State: <http://www.nclifelinks.org/ahcdr/>

My Desire for a Natural Death

I, _____, being of sound mind, desire that, as specified below, my life not be prolonged by life-prolonging measures:

1. When My Directives Apply

My directions about prolonging my life shall apply *IF* my attending physician determines that I lack capacity to make or communicate health care decisions and:

NOTE: YOU MAY INITIAL ANY OR ALL OF THESE CHOICES.

_____ (Initial)	I have an incurable or irreversible condition that will result in my death within a relatively short period of time.
_____ (Initial)	I become unconscious and my health care providers determine that, to a high degree of medical certainty, I will never regain my consciousness.
_____ (Initial)	I suffer from advanced dementia or any other condition which results in the substantial loss of my cognitive ability and my health care providers determine that, to a high degree of medical certainty, this loss is not reversible.

What's the Difference?

- **Healthcare Power of Attorney** – document that designates a “health care agent” and their powers.

HEALTH CARE POWER OF ATTORNEY

NOTE: YOU SHOULD USE THIS DOCUMENT TO NAME A PERSON AS YOUR HEALTH CARE AGENT IF YOU ARE COMFORTABLE GIVING THAT PERSON BROAD AND SWEEPING POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. THERE IS NO LEGAL REQUIREMENT THAT ANYONE EXECUTE A HEALTH CARE POWER OF ATTORNEY.

EXPLANATION: You have the right to name someone to make health care decisions for you when you cannot make or communicate those decisions. This form may be used to create a health care power of attorney, and meets the requirements of North Carolina law. However, you are not required to use this form, and North Carolina law allows the use of other forms that meet certain requirements. If you prepare your own health care power of attorney, you should be very careful to make sure it is consistent with North Carolina law.

This document gives the person you designate as your health care agent broad powers to make health care decisions for you when you cannot make the decision yourself or cannot communicate your decision to other people. You should discuss your wishes concerning life-prolonging measures, mental health treatment, and other health care decisions with your health care agent. Except to the extent that you express specific limitations or restrictions in this form, your health care agent may make any health care decision you could make yourself.

This form does not impose a duty on your health care agent to exercise granted powers, but when a power is exercised, your health care agent will be obligated to use due care to act in your best interests and in accordance with this document.

This Health Care Power of Attorney form is intended to be valid in any jurisdiction in which it is presented, but places outside North Carolina may impose requirements that this form does not meet.

If you want to use this form, you must complete it, sign it, and have your signature witnessed by two qualified witnesses and proved by a notary public. Follow the instructions about which choices you can initial very carefully. Do not sign this form until two witnesses and a notary public are present to watch you sign it. You then should give a copy to your health care agent and to any alternates you name. You should consider filing it with the Advance Health Care Directive Registry maintained by the North Carolina Secretary of State: <http://www.nclifelinks.org/ahodr/>

1. Designation of Health Care Agent.

I, _____, being of sound mind, hereby appoint the following person(s) to serve as my health care agent(s) to act for me and in my name (in any way I could act in person) to make health care decisions for me as authorized in this document. My designated health care agent(s) shall serve alone, in the order named.

A. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
Cellular Telephone: _____

B. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
Cellular Telephone: _____

C. Name: _____ Home Telephone: _____
Home Address: _____ Work Telephone: _____
Cellular Telephone: _____

What's the Difference

- **NC Practical Form** – document is a combination of living will + designation of health care agent.

An Advance Directive For North Carolina A Practical Form for All Adults

Introduction

This form allows you to express your wishes for future health care and to guide decisions about that care. It does not address financial decisions. Although there is no legal requirement for you to have an advance directive, completing this form may help you to receive the health care you desire.

If you are 18 years old or older and are able to make and communicate health care decisions, you may use this form.

This form has three parts. You may complete Part A only, or Part B only, or both Parts A and B. To make this advance directive legally effective, you must complete Part C of this form. Please keep all five pages of this form together and include all five pages of the form in any copies you may share with your loved ones or health care providers.

This form complies with North Carolina law (in NCGS § 32A-15 through 32A-27 and § 90-320 through 90-322).

Part A: Health Care Power of Attorney

1. **What is a health care power of attorney?** A health care power of attorney is a legal document in which you name another person, called a "health care agent," to make health care decisions for you when you are not able to make those decisions for yourself.
2. **Who can be a health care agent?** Any competent person who is at least 18 years old and who is not your paid health care provider may be your health care agent.
3. **How should you choose your health care agent?** You should choose your health care agent very carefully, because that person will have broad authority to make decisions about your health care. A good health care agent is someone who knows you well, is available to represent you when needed, and is willing to honor your wishes. It is very important to talk with your health care agent about your goals and wishes for your future health care, so that he or she will know what care you want.
4. **What decisions can your health care agent make?** Unless you limit the power of your health care agent in Section 2 of Part A of this form, your health care agent can make all health care decisions for you, including:
 - starting or stopping life-prolonging measures
 - decisions about mental health treatment
 - choosing your doctors and facilities
 - reviewing and sharing your medical information
 - autopsies and disposition of your body after death
5. **Can your health care agent donate your organs and tissues after your death?** Yes, if you choose to give your health care agent this power on the form. To do this, you must initial the statement in Section 3 of Part A.
6. **When will this health care power of attorney be effective?** This document will become effective if your doctor determines that you have lost the ability to make your own health care decisions.

What's the Difference?

- **Five Wishes** – “easy-to-use” booklet written in everyday language that allows designation of health care agent + more specific end of life wishes.

I wish to have pictures of my loved ones in my room, near my bed.

I wish to have my favorite music played when possible until my time of death.

I want to die in my home, if that can be done.

- After my death, I would like my body to be (circle one): buried *OR* cremated.
- My body or remains should be put in the following location: _____
- The following person knows my funeral wishes: _____

FIVE WISHES[®]

MY WISH FOR:

- 1 The Person I Want to Make Care Decisions for Me When I Can't
- 2 The Kind of Medical Treatment I Want or Don't Want
- 3 How Comfortable I Want to Be
- 4 How I Want People to Treat Me
- 5 What I Want My Loved Ones to Know

Print Your Name

Birthdate

What's the Difference?

- **Supplemental Advance Directive for Dementia** – supplements an existing AD if individual chooses VSED at time of “chosen end point” of progressed dementia and has a designated health care agent in agreeance to advocate on individuals behalf.



Introduction to our Supplemental Advance Directive For Dementia

Final Exit Network's Supplemental Advance Directive for Dementia Care (SADD) is available for individuals to use. But please remember that this directive is not for everybody. It is only for relatively knowledgeable users of advance directives, those who have given plenty of thought to this issue and who have made up their minds: they would choose self-deliverance by VSED (voluntarily stopping eating and drinking) over being spoon fed for years after they cannot or would not otherwise eat.

You must also have a healthcare surrogate who is completely comfortable with this request and who is prepared to argue with healthcare providers on your behalf.

You and your surrogate must also understand that there is very little legal guidance in state cases and that your request may not be honored. However, inclusion of such a statement does help improve the chances of it being upheld, as well as generally contributing to a climate in which such requests become the norm.

What's the Difference?

- **Psychiatric Advance Directive (PAD)**
 - document stating treatment preferences in the case of a mental health crisis that prevents decisional capacity, also referred to as “Mental Health Advance Directive.”

STATE OF NORTH CAROLINA

**ADVANCE INSTRUCTION FOR
MENTAL HEALTH TREATMENT**

COUNTY OF _____

**(NOTICE TO PERSON MAKING AN INSTRUCTION FOR MENTAL HEALTH
TREATMENT)**

This is an important legal document. It creates an instruction for mental health treatment. You should consider filing it with the Advanced Health Care Directive Registry maintained by the North Carolina Secretary of State: <http://www.sosnc.gov/health>.

Before signing this document you should know these important facts:

*This document allows you to make decisions in advance about certain types of mental health treatment. The instructions you include in this declaration will be followed if a physician or eligible psychologist determines that you are incapable of making and communicating treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments. Your instructions may be overridden if you are being held in accordance with civil commitment law. Under the Health Care Power of Attorney you may also appoint a person as your health care agent to make treatment decisions for you if you become incapable. You have the right to revoke this document at any time you have not been determined to be incapable. **YOU MAY NOT REVOKE THIS ADVANCE INSTRUCTION WHEN YOU ARE FOUND INCAPABLE BY A PHYSICIAN OR OTHER AUTHORIZED MENTAL HEALTH TREATMENT PROVIDER.** A revocation is effective when it is communicated to your attending physician or other provider. The physician or other provider shall note the revocation in your medical record. To be valid, this advance instruction must be signed by two qualified witnesses, personally known to you, who are present when you sign or acknowledge your signature. It must also be acknowledged before a notary public.*

NOTICE TO PHYSICIAN OR OTHER MENTAL HEALTH TREATMENT PROVIDER

Under North Carolina law, a person may use this advance instruction to provide consent for future mental health treatment if the person later becomes incapable of making those decisions. Under the Health Care Power of Attorney the person may also appoint a health care agent to make mental health treatment decisions for the person when incapable. A person is “incapable”

What's the Difference? Continued..

~ Must be obtained from medical provider ~

- **DNR** – resuscitation will not be initiated following event of cardiopulmonary arrest; does not affect other medical or comfort care.
- **MOST** – document is combination of DNR option + specification of medical treatment and wishes.



Effective Date: _____
Expiration Date, if any _____

Check box if no expiration

DO NOT RESUSCITATE ORDER

Patient's full name _____

In the event of cardiac and/or pulmonary arrest of the patient, efforts at cardiopulmonary resuscitation of the patient SHOULD NOT be initiated. This order does not affect other medically indicated and comfort care.

I have documented the basis for this order and the consent required by the NC General Statute 90-21.17(b) in the patient's records.

Signature of Attending Physician/Physician Assistant/Nurse Practitioner _____

Printed Name of Attending Physician _____

Address _____

City, State, Zip _____

Telephone Number (office) _____

Telephone Number (emergency) _____

Do Not Copy Do Not Alter



HIPAA PERMITS DISCLOSURE OF MOST TO OTHER HEALTH CARE PROFESSIONALS AS NECESSARY



Medical Orders for Scope of Treatment (MOST)

This is a Physician Order Sheet based on the person's medical condition and wishes. Any section not completed indicates full treatment for that section. **When the need occurs, first follow these orders, then contact physician.**

Patient's Last Name: _____

Effective Date of Form: _____

Form must be reviewed at least annually.

Patient's First Name, Middle Initial: _____

Patient's Date of Birth: _____

Section A

Check One Box Only

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

Attempt Resuscitation (CPR)

Do Not Attempt Resuscitation (DNR/no CPR)

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

Section B

Check One Box Only

MEDICAL INTERVENTIONS: Person has pulse and/or is breathing.

Full Scope of Treatment: Use intubation, advanced airway interventions, mechanical ventilation, cardioversion as indicated, medical treatment, IV fluids, etc.; also provide comfort measures. **Transfer to hospital if indicated.**

Limited Additional Interventions: Use medical treatment, IV fluids and cardiac monitoring as indicated. Do not use intubation or mechanical ventilation; also provide comfort measures. **Transfer to hospital if indicated. Avoid intensive care.**

Comfort Measures: Keep clean, warm and dry. 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. **Do not transfer to hospital unless comfort needs cannot be met in current location.**

Other Instructions _____

Section C

Check One Box Only

ANTIBIOTICS

Antibiotics if life can be prolonged

Determine use or limitation of antibiotics when infection occurs.

No Antibiotics (use other measures to relieve symptoms).

Other Instructions _____

Section D

Check One Box Only in Each Column

MEDICALLY ADMINISTERED FLUIDS AND NUTRITION: Offer oral fluids and nutrition if physically feasible.

IV fluids long-term if indicated

Feeding tube long-term if indicated

IV fluids for a defined trial period

Feeding tube for a defined trial period

No IV fluids (provide other measures to ensure comfort)

No feeding tube

Other Instructions _____

Section E

Check The Appropriate Box

DISCUSSED WITH

AND AGREED TO BY:

Patient

Parent or guardian if patient is a minor

Health care agent

Legal guardian of the person

Attorney-in-fact with power to make health care decisions

Spouse

Majority of patient's reasonably available parents and adult children

Majority of patient's reasonably available adult siblings

An individual with an established relationship with the patient who is acting in good faith and can reliably convey the wishes of the patient

Basis for order must be documented in medical record.

MD/DO, PA, or NP Name (Print): _____

MD/DO, PA, or NP Signature (Required): _____

Phone #: _____

Signature of Person, Parent of Minor, Guardian, Health Care Agent, Spouse, or Other Personal Representative (Signature is required and must either be on this form or on file)

I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician (MD/DO), physician assistant, or nurse practitioner. This document reflects those treatment preferences and indicates informed consent.

If signed by a patient representative, preferences expressed must reflect patient's wishes as best understood by that representative. Contact information for personal representative should be provided on the back of this form.

You are not required to sign this form to receive treatment.

Patient or Representative Name (print) _____

Patient or Representative Signature _____

Relationship (write "self" if patient) _____

SEND FORM WITH PATIENT/RESIDENT WHEN TRANSFERRED OR DISCHARGED

Ask the OCDoA about our DNR bracelets! We can upload your DNR or MOST forms to ensure emergency responders are aware of your active order and that your wishes are honored in the case of an emergency.



Five Steps for Advance Care Planning



- **Think.** Think about what matters to you.
- **Talk.** Talk about your wishes with your family, friends, and medical providers.
- **Put it in writing.** Document your choices and decisions.
- **Share.** Share your documents with your family, friends, and medical providers (MyChart).
- **Review.** Review your advance care documents at least once a year.

Choosing a Health Care Agent/Proxy

- You may not choose someone under the age of 18.
- If you're a patient in a health care facility, you may not choose an employee of that facility (unless the person is a relative).
- You may not choose a member of your current health care team (doctor, nurse, etc.)

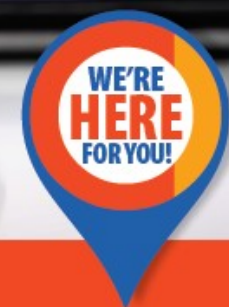
NC does not have restrictions related to beneficiaries/financial PoA also being the health care proxy.

Advance Directives 101

Did you know “advance directive” is an umbrella term?

There are actually several versions to choose from including a **living will**, **Five Wishes**, **healthcare power of attorney**, and more.

For notary services or to learn more about your options, contact the **Aging Helpline** at 919-968-2087 or agingtransitions@orangecountync.gov.



Copies of advance directives available upon request.
Note: Excludes DNR and MOST as these can only be obtained from a physician.



www.orangecountync.gov/Aging

