

LIVING WILL / DECLARATION

1. Fill in all blanks and check all life-sustaining procedures that you choose to have withheld or withdrawn under those circumstances set forth in the Living Will.
2. Sign original Living Will in the presence of two (2) witnesses who are not related to you by blood or marriage and who are not going to inherit from you.
3. Give one copy of your Living Will to your physician.
4. Give one copy of your Living Will to a friend or relative who can be trusted to produce the Living Will in the event that you are certified by two (2) physicians to be suffering from a terminal and irreversible condition or to be in a continual profound comatose state with no reasonable chance of recovery and that the application of life sustaining procedures would serve only to prolong artificially the dying process.

STATE OF LOUISIANA PARISH OF _____

Declaration made _____ this day of _____ 20 ____.

I, _____ being of sound mind, willfully and voluntarily hereby make it known my express will and Directive that my dying shall not be artificially prolonged under the circumstances set forth below and hereby declare that is, at any time. I should have an incurable injury, disease or illness and be certified by two (2) physicians who have personally examined me (one of who shall be my attending physician) stating that I am suffering from terminal and irreversible condition, or to be in a continual profound comatose state, no reasonable chance of recovery, and the said physicians determines that the application of life-sustaining procedure would serve only to prolong artificially to the provision of any valid document executed by me providing for the donation of any of my organ(s), such life-sustaining procedures be withheld or withdrawn and that I be permitted to die naturally with only the administration of medication or the for performance of any medical procedure deemed necessary to provide me with comfort care.

The life-sustaining procedures I choose to have withheld or withdrawn include but are not limited to: (check all that apply)

- _____ Heart-Lung Resuscitation (CPR)
- _____ Mechanical Ventilator (respiratory)
- _____ Tube Feeding (food and water delivered through a tube)
- _____ Intravenous Feeding (nutrition or fluids through a CV tube)
- _____ Other _____

In the absence of my ability to give directions regarding the use of such life-sustaining procedures it is my intention that this declaration be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full importance of this declaration and I am emotionally and mentally competent to make this declaration.

This declaration is made and signed by me in the presence of the undersigned witnesses who are not related to me by blood or marriage and who do not stand to inherit from me.

Signature of Declarant _____

The declarant is known to me and I believe the declarant to be of sound mind.

Witness _____ Date _____

Witness _____ Date _____

POWER OF ATTORNEY FOR DECISIONS

1. Fill in the blanks including home address and telephone of those whom you are authorizing to make health care decisions for you.
2. Sign in the presence of two (2) witnesses.
3. Give to persons named in this document.

STATE OF LOUISIANA, PARISH OF _____

I, _____ being of sound mind, do hereby designate (name) _____, (address)

_____ (telephone),
_____, to serve as my attorney-in-fact with full authority to make health care and treatment decisions for me, including decisions concerning surgery, medical expenses, hospitalization, selections of physicians, nursing home residency and medications, in the event that I am determined by my physician to be physically or mentally incapable of making such decisions. Such attorney has full authority to make such decisions fully, completely, and effectually, and to all intents and purposes with the same validity as if such decisions had been personally made by me. It is my understanding and intention that decisions concerning the withholding or withdrawal of life sustaining procedures are not governed by this Power of Attorney but may be governed by fully executed Living Will/Declaration.

Thus done and signed this _____ day of _____, 20____

(Signature of Declaration) _____

(Address) _____

(Witness) _____

(Witness) _____

IMPORTANT TERMINOLOGY

AN ADVANCE DIRECTIVE is a document written before a disabling illness. The advance directive states your choice about treatment and may name someone to make treatment choices if you can not.

Louisiana Law provides for two types of Advance Directives, the Living Will and Durable Power of Attorney.

A **LIVING WILL** is a legal document that allows you to make your wishes known concerning artificially, life-supporting treatment. This is executed in advance of the time when you may not be able to participate in those decisions and can be canceled at the time, in writing or by telling someone. Living will forms and declarations are available on request from the home health office.

A **DURABLE POWER OF ATTORNEY** is a legal document, which allows you to designate a particular person to make decisions regarding your medical care when you are not able to do so. This should be someone you trust to carry out your wishes. It may also be canceled or changed at any time. There are several types of durable powers of attorney. Only a durable power of attorney gives someone the authority to make health care decisions, one for business and one for personal decisions.

Both of these documents must be signed by two witnesses. Those witnesses may not be relatives; anyone entitled to any part of your estate upon your death or your health care providers. It is also recommended that your Living Will be notarized, but the law does not require this. A Durable Power of Attorney must be notarized. You should give a copy of your living will/durable power of attorney to your doctor, family or friends, and health care providers. Keep the originals with other important papers in a safe place that is easy to find. Please inform us if you execute or change either of these documents during the course of your care.

NOTIFICATION: There are a number of ways to ensure that your decisions are conveyed to the appropriate people. Copies of your Living Will and Durable Power of Attorney for Healthcare should be given to your attorney, your nearest

relatives, and your healthcare provider. You must also notify your physician. Notification is **your** responsibility. You may register your declaration with the Office of Secretary of State, although you are not obligated to do so. Send either a certified copy or the original itself to:

Office of Secretary of State
Post Office Box 94125
Baton Rouge, LA 70804-9125

There is a fee, so please call 504-342-4980 for more information Life Source Home Health has copies of living will forms available upon request.

CHANGING YOUR DECISION: You may cancel, revoke or change your Declaration at any time by (1)canceling defacing your declaration, (2) writing to express your desire to revoke, (3)expressing, either verbally or nonverbally, your desire to revoke, (4) filling a written notice of revocation with the Secretary of State, is you registered your declaration.

An **ETHICS COMMITTEE** is available to serve in an advisory capacity when ethical issues, such as the withdrawal or withholding of life-sustaining treatment arise during the care of patients without an advance directive. Discussion shall involve the patient's physician.