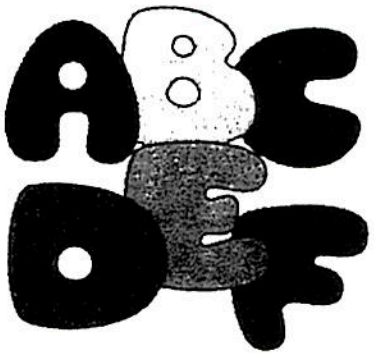

POAHC, DNR, POLST– The Alphabet Soup of Advance Directives

Living Will
DECLARATION

This declaration is made this _____ day of_____ (month, year).

I, _____, born on _____, 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for death delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary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 _____

History
(Source: P.A. 85-1209.)
Annotations
Note. This section was Ill.Rev.Stat., Ch. 110 1/2, Para. 703.

Rev 5/2012

(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.)

- 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 these 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 _____

(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.

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.)

Illinois Department of Public Health

UNIFORM DO-NOT-RESUSCITATE (DNR) ADVANCE DIRECTIVE

Patient's name _____

Summarize medical condition:

When This Form Should Be Reviewed

This DNR order, in effect until revoked, should be reviewed periodically, particularly if –

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status, or
- The patient/resident treatment preferences change.

How to Complete the Form Review

1. Review the other side of this form.
2. Complete the following section.
   If this form is to be voided, write "VOID" in large letters on the other side of the form.
   After voiding the form, a new form may be completed.

Date	Reviewer	Location of review	Outcome of Review
			❑ No change ❑ FORM VOIDED; new form completed ❑ FORM VOIDED; no new form completed
			❑ No change ❑ FORM VOIDED; new form completed ❑ FORM VOIDED; no new form completed
			❑ No change ❑ FORM VOIDED; new form completed ❑ FORM VOIDED; no new form completed

Advance Directives

I also have the following advance directives:

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

Contact person (name and phone number)

_____

_____

_____

◆ *Send this form or a copy of both sides with the individual upon transfer or discharge.* ◆

H0190-0200

Illinois Department of Public Health

UNIFORM DO-NOT-RESUSCITATE (DNR) ADVANCE DIRECTIVE

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

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

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.

See also Guidance for Health Care Professionals at http://www.idph.state.il.us/public/books/advin.htm.

Patient Last Name	Patient First Name	MI

Date of Birth (mm/dd/yy)	Gender ☐ M ☐ F

Address (street/city/state/ZIPcode)

A Check One

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

- ☐ **Attempt Resuscitation/CPR** (*Selecting CPR means* **Intubation and Mechanical Ventilation** *in Section* **B** *is selected*)
- ☐ **Do Not Attempt Resuscitation/DNR**

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

B Check One

MEDICAL INTERVENTIONS Patient has pulse and/or is breathing.

- ☐ **Comfort Measures Only** (Allow Natural Death). Relieve pain and suffering through the use of medication by appropriate route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital*** *for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.* **Treatment Plan: Maximize comfort through symptom management.**
- ☐ **Limited Additional Interventions** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation or mechanical ventilation. May consider less invasive airway support (e.g., CPAP, BiPAP). ***Transfer to hospital if indicated. Generally avoid the intensive care unit.*** **Treatment Plan: Provide basic medical treatments.**
- ☐ **Intubation and Mechanical Ventilation** In addition to care described in Comfort Measures Only and Limited Additional Interventions, use intubation and mechanical ventilation as indicated. ***Transfer to hospital*** *and/or intensive care unit if indicated.* **Treatment Plan: Life support measures, including intubation, in the intensive care unit.**
- ☐ **Additional Orders** _____

C Check One *(optional)*

ARTIFICIALLY ADMINISTERED NUTRITION Offer food by mouth, if feasible and as desired.

- ☐ No artificial nutrition by tube.
- ☐ Defined trial period of artificial nutrition by tube.
- ☐ Long-term artificial nutrition by tube.

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

_____

_____

D

DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

- ☐ Patient
- ☐ Parent of minor
- ☐ Agent under health care power of attorney
- ☐ 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 ATTENDING PHYSICIAN

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 Attending Physician Name *(required)*	Phone
	( ) _____ - _____

Attending Physician Signature *(required)*	Date *(required)*

UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE ■ UNIFORM DNR ADVANCE DIRECTIVE

THIS SIDE FOR INFORMATIONAL PURPOSES ONLY		
Patient Last Name	Patient First Name	MI

The Illinois Department of Public Health (IDPH) Uniform Do Not Resuscitate (DNR) Advance Directive is **always voluntary** and is for persons with advanced or serious illness or frailty. 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 form (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 Uniform Do Not Resuscitate (DNR) Advance Directive Form

- **The completion of a DNR form is always voluntary, cannot be mandated and may be changed at any time.**
- A DNR form should reflect current preferences of persons with advanced or serious illness or frailty. Also, encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by attending physician 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 Do Not Resuscitate (DNR) Advance Directive Form

This DNR form should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another,
- or there is a substantial change in the patient's health status,
- or the patient's treatment preferences change,
- or the patient's primary care professional changes.

Voiding or revoking a Do Not Resuscitate (DNR) Advance Directive Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a DNR form requires completion of a new DNR form.
- Draw line through sections A through E and write "VOID" in large letters if any DNR 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://www.idph.state.il.us/public/books/advin.htm

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

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

IDPH DNR/POLST

State of Illinois
Illinois Department of Public Health

DO-NOT-RESUSCITATE (DNR)/PRACTITIONER ORDERS 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** (*Selecting CPR means* **Full Treatment** *in Section B is selected*)

☐ **Do Not Attempt Resuscitation/DNR**

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
☐ Parent of minor
☐ Agent under health care power of attorney
☐ 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 Attending 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 Attending Practitioner Name *(required)*	Phone
	( ) _____ - _____

Attending Practitioner Signature *(required)*	Date *(required)*

Form Revision Date January 2015 (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 • 2015

"THIS SIDE FOR INFORMATIONAL PURPOSES ONLY"

Patient Last Name	Patient First Name	MI

The Illinois Department of Public Health (IDPH) Do Not Resuscitate (DNR)/Practitioner Orders for Life Sustaining Treatment (POLST) **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 form (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.

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Contact Person Name	Contact Phone Number

Health Care Professional Information

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

Completing the IDPH Do Not Resuscitate (DNR)/POLST Form

- **The completion of a DNR/POLST form is always voluntary, cannot be mandated and may be changed at any time.**
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- or the patient's treatment preferences change,
- or the patient's primary care professional changes.

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- Changing, modifying or revising a DNR/POLST form requires completion of a new DNR/POLST form.
- Draw line through sections A through E and write "VOID" across page if any DNR/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://www.idph.state.il.us/public/books/advin.htm

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

Code Status Definitions

A. Code status	Full	DNR	DNR	DNR
B. Interventions	Full	Full	Selective	Comfort
Compressions	Yes	No	No	No
Intubation	Yes	Yes	No	No
Defibrillation	Yes	Yes	No	No
Vasopressors	Yes	Yes	Yes	No