

Advance Directives

Comfort, Support & Care



The Patient Self-Determination Act is a federal law that requires hospitals to provide written information to adult patients concerning “an individual’s right under state law ... to make decisions concerning ... medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives.”

To help patients make these choices, Kansas law provides for advance directives, which are written documents that include a durable power of attorney for healthcare decisions; a living will; and a do not resuscitate directive, which often is referred to as a DNR.

Durable power of attorney for healthcare decisions

This document will allow you to appoint someone — or more than one person — to carry out your healthcare decisions when you are not able to make those decisions. It gives a healthcare agent — often a relative, spouse or friend — legal authority to make healthcare decisions when you are incapacitated. Your agent must be 18 or older. For this document to be valid, it must be dated and signed in the presence of at least two witnesses who are at least 18 or it must be notarized. Neither witness can be your agent or related to you by blood, marriage or adoptions; entitled to any portion of your estate; or directly financially responsible for your healthcare. Kansas law requires two witnesses for these documents or they may be notarized. Missouri law requires notarization of your signature. LMH Health has notary publics available from 8:30 a.m. to 4:30 p.m., Monday through Friday.

Living will

A living will instructs your physicians, healthcare providers and family about what type of medical care you want — or do not want — when you are facing end-of-life care, and when you become unable to make end-of-life care decisions for yourself if your condition is determined to be terminal by two physicians. Your

choices may include receiving, withholding or withdrawing life sustaining treatment.

Do not resuscitate directive

A DNR directive is a signed, dated and witnessed document that allows an adult to state in advance his/her decision that if his/her heart stops beating or breathing stops, no medical procedure will be undertaken to restart the heart or breathing.

Who should have a copy of your advance directives?

- You, your family, your significant other
- The person who is your durable power of attorney for healthcare and that person’s proxy
- Your primary physician(s)
- Your hospital(s)
- Other healthcare providers

LMH Health Patient Self-Determination Act Policy

During admission, every adult patient will be provided with material that summarizes Kansas law for a patient to make decisions regarding medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate a living will or durable power of attorney for healthcare.

During the admission process, all adult inpatients will be asked

if they have executed advance directives. The patient’s statement will be recorded on the nursing admissions assessment form.

For purposes of this policy, advance directives are defined to include living wills (KSA 65-28, 103) durable power of attorney for healthcare decisions (KSA 58-632) and do not resuscitate directives (65-4942).

No member of the staff or employee of the hospital may in any way discriminate against an individual based on whether the individual has executed advance directives.

The hospital will provide education for the staff and community on issues concerning advance directives.

Care Coordination LMH Health

325 Maine Street
Lawrence, KS 66044
785-505-6149

Center for Practical Bioethics

Harzfeld Building
1111 Main Street, Suite 500
Kansas City, MO 64105
800-344-3829
816-221-1100
fax: 816-221-2002
bioethic@practicalbioethics.org
www.practicalbioethics.org

Palliative Support Services

LMH Health
330 Arkansas St., Suite 210
Lawrence, KS 66044
785-505-5623
785-393-0787

Advance directives for healthcare at LMH Health

This packet contains advance directive forms to help you make healthcare choices. Here's some information about these three documents.

Durable power of attorney for healthcare decisions

This allows you to appoint a person to act as your decision maker for healthcare matters if you become incapacitated and are unable to make informed choices.

Living will

This allows you to express your choices for end-of-life care in writing and is referred to only if you become incapacitated and are terminally ill.

Do not resuscitate directive

This is signed, dated and witnessed and allows an adult to state in advance his/her decision that if his/her heart stops beating or breathing stops, no medical procedure will be undertaken to restart the heart or breathing. This document must be signed by a physician.

Guidelines

Please read the documents very carefully. LMH Health has chosen these advance directive forms because they are concise and relatively universal. However, like all legal documents, they can be confusing, and they must be properly completed to be effective. It is a good idea to discuss signing these documents with your physician, family or other people who need to know about your choices.

- You may make as many copies of the document as you need. Make sure you copy both sides.
- Your signature must be witnessed by two people who are at least 18. Neither witness can be your agent or related to you by blood, marriage or adoptions; entitled to any portion of your estate; or directly financially responsible for your healthcare.
- LMH Health requests that its nursing staff and physicians not be witnesses. A Care Coordination staff member will be glad to arrange two witnesses.
- Kansas law does not require that the form be notarized. Missouri law does have that requirement. LMH Health has personnel who can notarize your document between 8:30 a.m. and 4:30 p.m., Monday through Friday. It is a good idea to have your advance directives notarized if you plan to travel. It is more likely that other states will honor your document if you have two witnesses and a notary's signature.
- Give copies to as many people as you wish including:
 - Physician or physicians
 - Health Information Management (medical records) at LMH Health. Please put your birth date on the form so we can find your medical record.
 - The person you have designated on the form
 - Family
 - Attorney
- We urge you to discuss the signing of this document with those whom you trust. For further information contact Care Coordination at 785-505-6149. If you are in the hospital and need more information, or wish to sign the document and need witnesses and/or a notary, call 6149.

DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS
GENERAL STATEMENT OF AUTHORITY GRANTED

I, _____, designate and appoint:

Name _____

Address: _____

Telephone Number: _____ to be my agent for healthcare decisions and pursuant to the language stated below, on my behalf to:

- (1) Consent, refuse consent, or withdraw consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition, and to make decisions about organ donation, autopsy and disposition of the body;
- (2) make all necessary arrangements at any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge healthcare personnel to include physicians, psychiatrists, psychologists, dentists, nurses, therapists or any other person who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer healthcare as the agent shall deem necessary for my physical, mental and emotional well being; and
- (3) request, receive and review any information, verbal or written, regarding my personal affairs or physical or mental health including medical and hospital records and to execute any releases of other documents that may be required in order to obtain such information.

In exercising the grant of authority set forth above my agent for healthcare decisions shall:

(Here may be inserted any special instructions or statement of the principal's desires to be followed by the agent in exercising the authority granted).

LIMITATIONS OF AUTHORITY

- (1) The powers of the agent herein shall be limited to the extent set out in writing in this durable power of attorney for healthcare decisions, and shall not include the power to revoke or invalidate any previously existing declaration made in accordance with the natural death act.
- (2) The agent shall be prohibited from authorizing consent for the following items:

- _____

(3) This durable power of attorney for healthcare decisions shall be subject to the additional following limitations:

EFFECTIVE TIME

This power of attorney for healthcare decisions shall become effective (immediately and shall not be affected by my subsequent disability or incapacity or upon the occurrence of my disability or incapacity).

REVOCAATION

Any durable power of attorney for healthcare decisions I have previously made is hereby revoked.

(This durable power of attorney for healthcare decisions shall be revoked by an instrument in writing executed, witnessed or acknowledged in the same manner as required herein or set out another manner of revocation, if desired.)

EXECUTION

Executed this _____, at _____, Kansas. _____ Principal.

This document must be: (1) Witnessed by two individuals of lawful age who are not the agent, not related to the principal by blood, marriage or adoption, not entitled to any portion of principal's estate and not financially responsible for principal's healthcare; OR (2) acknowledged by a notary public.

Witness

Witness

Address

Address

(OR)

STATE OF _____

SS.

COUNTY OF _____)

This instrument was acknowledged before me on _____ (date)
by _____ (name of person)

(Signature of notary public)

My appointment expires: _____ (Seal, if any)

Ks Statute 58-632

Patient Label

LIVING WILL

- a) Any adult person may execute a declaration directing the withholding or withdrawal of life-sustaining procedures in a terminal condition. The declaration made pursuant to this act shall be: (1) In writing; (2) signed by the person making the declaration, or by another person in the declarant's presence and by the declarant's expressed direction; (3) dated; and (4)(A) signed in the presence of two or more witnesses at least 18 years of age neither of whom shall be the person who signed the declaration on behalf of and at the direction of the person making the declaration, related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession of this state or under any will of the declarant or codicil thereto, or directly financially responsible for declarant's medical care; or (B) acknowledged before a notary public. The declaration of a qualified patient diagnosed as pregnant by the attending physician shall have no effect during the course of the qualified patient's pregnancy.
- (b) It shall be the responsibility of declarant to provide for notification to the declarant's attending physician of the existence of the declaration. An attending physician who is so notified shall make the declaration, or a copy of the declaration, a part of the declarant's medical records.
- (c) The declaration shall be substantially in the following form, but in addition may include other specific directions. Should any of the other specific directions be held to be invalid, such invalidity shall not affect other directions of the declaration which can be given effect without the invalid direction, and to this end the directions in the declaration are severable.

DECLARATION

Declaration made this _____ day of _____ (month, year).

I _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall 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 import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

City, County and State of Residence _____

The declarant has been personally known to me and I believe the declarant to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not related to the declarant by blood or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care.

Witness

Witness

(OR)

STATE OF _____

SS.

COUNTY OF _____)

This instrument was acknowledged before me on _____ (date)

by _____ (name of person)

(Signature of notary public)

(Seal, if any)

My appointment expires: _____

Patient Label

Ks Statute 65-28,103

PRE-HOSPITAL DNR REQUEST FORM

An advanced request to Limit the Scope of Emergency Medical Care

I, _____ (name) request limited emergency care as herein described.

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will not prevent me from obtaining other emergency medical care by pre-hospital care providers or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time.

I give permission for this information to be given to the pre-hospital care providers, doctors, nurses or other healthcare personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) directive.

Signature

Date

Witness

Date

I AFFIRM THIS DIRECTIVE IS THE EXPRESSED WISH OF THE PATIENT, IS MEDICALLY APPROPRIATE, AND IS DOCUMENTED IN THE PATIENT'S PERMANENT MEDICAL RECORD.

In the event of an acute cardiac or respiratory arrest, no cardiopulmonary resuscitation will be initiated.

Attending Physician's Signature*

Date

Address

Facility or Agency Name

*Signature of physician not required if the above-named is a member of a church or religion which, in lieu of medical care and treatment, provides treatment by spiritual means through prayer alone and care consistent therewith in accordance with the tenets and practices of such church or religion.

REVOCATION PROVISION

I hereby revoke the above declaration.

Signature

Date

Ks. Statute 65-4942

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Back of DNR form

Patient Label

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LMH Health provides care that is sensitive to cultural, racial, religious and other differences and does not discriminate on the basis of race, religion, age, ethnicity, culture, language, socio-economic status, sex, sexual orientation, gender identity or expression, national origin, physical or mental disability, or source of payment, nor in relation to employment practices.

04/2019

