Advance Care Planning Form and Reference Guide

Important Choices with Your Care

About Advance Care Planning

An advance care plan gives instructions about the health care you want as an adult 18 years of age or older if you become too hurt or ill to speak for yourself. It also allows you to name someone to make decisions on your behalf. Even if you're in good health, it's still important to make sure your health care team and loved ones know your wishes. Because your health status could change suddenly, often the most ideal time to make these decisions is when you are not in crisis, allowing time to talk with your loved ones about your values and beliefs.

We are here to help you and your loved ones in this process. For more information:

- Visit **www.yorkhospital.com/care-management**
- Call Care Management at (207) 351-2226
- Contact the Health Care Help Center at (207) 351-2345
- The Center for Older Adults can be reached at (207) 351-2371
- Contact your primary care provider
- Contact Spiritual Care at (207) 361-3647

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Advance Care Planning
Important Choices with Your Care

Reference Guide

How Can I Use This Reference Guide?

This optional reference guide is intended to help patients and their loved ones navigate the care planning process. Information within this guide includes topics to consider when documenting final wishes, and where to go for additional help. Talking with your loved ones about your wishes at the end of your life can be hard. Yet, it is so important to be clear with those who are dear to us about what matters to us so that those wishes can be best honored.

Please Note: Advance Care Planning forms to fill out are located on pages 10-27, along with specific instructions.

Your answers to these questions can help provide you and your caregivers with peace of mind.

VALUES

- What gives your life its purpose and meaning?
- What do you value most about your physical or mental wellbeing? For example, do you love the outdoors? To read or listen to music? To be aware of whom you are with?

FAMILY/FRIEND RELATIONSHIPS

- Who among your family and friends are important in your life?
- Have you talked with your loved ones about the medical care choices to be made when problems arise or death comes close?

SPIRITUAL/RELIGIOUS BELIEFS

- How would you describe your spiritual or religious life?
- Do you have a faith community, church or synagogue who support you?
- Do you have religious beliefs about medical treatment?

MEDICAL

- Have you talked with your doctor or other health provider about your health concerns and medical treatment questions?
- Under what conditions would you want the goals of medical treatment to change from trying to continue your life to focusing on your comfort?
- Would you want a hospice team or palliative care offered to you?
- How does cost influence your decisions about medical care?
- Do you want CPR used to try to revive you if your heart stops or you stop breathing? How effective is CPR likely to be for you?

MAKING PLANS

- If you could plan it today, what would the last day or week of your life be like? Where would you be? Who would be with you?
- What will be important to you when you are dying (comfort, no pain, family present, music, prayer, being touched or held, etc.)?
- What general comments would you like to make about dying or death?
- Are you interested in organ or tissue donation?
- Are there people to whom you want to write a letter, or for whom you want to prepare a taped message, perhaps marked to be opened at a future time?
- What are your wishes for a memorial service: songs or readings you want, or people you hope will participate?
- Would you prefer to be buried or cremated, or do you have no preference? Have you contacted a funeral home?

Part 1 – Resources (pages 13-15)

Choosing Your Health Care Agent

Choose someone who knows you well, cares about you, and who can make difficult decisions. A spouse or family member may not be the best choice because they are too emotionally involved. Sometimes they are the best choice. You know best. Choose someone who is able to stand up for you so that your wishes are followed. Also, choose someone who is likely to be nearby so that they can help when you need them. Whether you choose a spouse, family member or friend as your Agent, make sure you talk about these wishes and be sure that this person agrees to respect and follow your wishes.

Items to consider include:

1. Does my agent meet legal criteria in my state?
2. Would they be willing to speak for me?
3. Could they act on my wishes, and separate their own feelings or beliefs?
4. Are they local? Can they be at my side when I need them?
5. Will they likely be available long into the future?
6. Could they navigate conflicting opinions between family, friends and my medical care team?
7. Can they be a strong advocate for my wishes?

Part 2 – Special Instructions (pages 16-18)

Making Choices with Life Sustaining Treatment Options

We all want to be treated with dignity. When we are no longer able to speak for ourselves, it is important that you clearly articulate your wishes and directions to your Health Care Agent. Life-support means any medical procedure, device or medication that is used to keep you alive. This may include helping you breathe, providing nourishment, resuscitation (CPR), surgery, blood products, medication or anything else meant to keep you alive.

If you wish to limit the meaning of life support treatment because of your beliefs, it is important to document your wishes clearly under "Other Directions" on page 18 of your Advance Care Planning booklet.

Items to consider include:

1. Do I want life support treatment?
2. If treatment has been started, do I want it stopped?
3. Do I want treatment if my provider believes it will help?
4. In what ways do I wish to be kept comfortable? (i.e. medicine, comfort measures, spiritual needs, etc.)
5. How do I want people to treat me? (i.e. visitors, prayer, music, etc.)

Part 3 – Primary Provider (page 19)
Part 4 – Donation of Organs (page 20)

Part 3 and Part 4 are each optional, to be filled out depending on your wishes.

Part 5 – Funeral and Burial Arrangements (page 21)

How Do I Want to be Honored or Remembered?
Items to consider include:

1. How do you want your remains handled after your death?
2. Who do I want to manage my remains?
3. What would I want a memorial service to look like?
   Do I want a memorial service at all?
4. Is there a charity I'd like donations made to upon my death?

If you wish to further define these wishes, please document your wishes clearly on page 21 of your Advance Care Planning booklet.

Next Steps

I've completed my Advance Care Planning documents. Now what? Items to consider include:

1. Sign and witness the form as instructed.
2. Talk about your decisions with your provider and your loved ones.
3. Keep your original document in a special place at home where it is accessible.
4. Provide copies of the document to your provider, hospital, close loved ones and your agent.

For more opportunities for support and discussion, consider a community outreach event. Visit https://yorkhospital.com/advancecareplanning to learn about upcoming events intended to foster dialog on end of life decisions in a meaningful and effective way.

Definitions to Consider

- **Allow Natural Death (AND)** Allow Natural Death is an alternative language used by some people who do not want CPR but want only comfort care.
- **Attending physician or attending advanced practice registered nurse (APRN) –** A doctor or APRN who has primary responsibility for your treatment

- **CPR or Cardiopulmonary resuscitation –** Emergency medical procedure used to try to restart heartbeat and breathing, which can involve blowing into the mouth, pushing on the chest, inserting a breathing tube into the windpipe, giving medicines into your vein, and electrical shock.
- **Comfort care –** Keeping you as comfortable and peaceful as possible, including pain medication, giving you ice chips and lip ointment, turning your body to prevent bed sores and bathing you.
- **DNR or Do Not Attempt Resuscitation order** – A medical order placed in your medical chart in a hospital or other health facility that says you do not want CPR performed if your heart or breathing stops. You can extend a DNR outside a hospital or health facility by completing a Portable-DNR order. It is a bright pink colored form that stays with the person who requests it.
- **Guardianship** – A guardianship of an incompetent person is established by the Probate Court when it determines that the functional limitations of a person have declined to the point where that person's ability to participate in and perform minimal activities of daily living is not present. Incompetence of the person must be proved "beyond a reasonable doubt" and there must be no other available solutions that would impose fewer restrictions on the person. The person loses the right to make a(ny) decision. The court appointed guardian shall make any decision.
- **Health care agent** – Someone chosen as your Durable Power of Attorney for Health Care to make health care decisions when you are unable to express your own wishes for care or treatment.
- **Health care decision** – This means informed consent, refusal to give informed consent or withdrawal of informed consent to any type of health care, treatment, admission to a health facility or procedure to diagnose or maintain an individual's physical or mental condition.
- **Hospice care** – A team approach to provide comprehensive medical, nursing and social services, spiritual care and bereavement support for you and your family near the end of life.
- **Intravenous or IV line –** A tube placed in your vein that is used to give you fluids, blood or medication.
- **Life–sustaining treatment** – "Life-sustaining treatment" includes, but is not limited to, the following: medically administered nutrition and hydration, mechanical respiration, kidney dialysis, or the use of other external mechanical or technological devices. "Life- sustaining treatment" may include drugs to maintain blood pressure, blood transfusions, and antibiotics. "Life-sustaining treatment" shall not include the administration of medication, natural ingestion of food or fluids by eating and drinking, or the performance of any medical procedure deemed necessary to provide comfort or to alleviate pain.

- **Medically administered nutrition (feeding) –** Using IVs or tubes to supply food when you are unable to eat. A feeding tube is a medical tube through which food or water is put into your body. It does not include the natural process of eating foods.
- **Medically administered hydration** – Using IVs or tubes to supply water when you are unable to drink. It does not include the natural process of drinking fluids.
- **Near death** – An incurable condition caused by injury, disease or illness that reasonable medical judgment finds will cause death at any time, so that life–sustaining treatment will only postpone death. This is determined by a doctor or APRN working with an additional doctor.
- **Organ and tissue donation** – Giving your usable organs for transplantation into others, which can save or improve their lives. Organs you can donate: heart, kidneys, pancreas, lungs, liver, and intestines. Tissue you can donate: cornea, skin, bone marrow, heart valves, and connective tissue. To be transplanted, organs must receive blood until they are removed from your body. Therefore, it may be necessary to place you on a breathing machine temporarily or provide other organ-sustaining treatment. Doctors evaluate whether you have organs or tissue suitable for transplant at or near the time of death. Your body can still be shown and buried after your death.
- **Palliative care** – Palliative care is specialized medical care for people living with serious illness. It focuses on providing relief from the symptoms and stress of a serious illness. The goal is to improve quality of life for both the patient and the family.
- **Permanently unconscious** – A lasting condition, indefinitely without improvement, in which you are not aware of your thought, yourself and environment and other indicators of consciousness are absent as determined by a neurological assessment by a doctor in consultation with your doctor or APRN.
- **Persistent vegetative state** – An irreversible condition where reasonable medical judgment finds the complete loss of key brain functions. It results in the end of all thinking and consciousness, although heartbeat and breathing continue. Periods of sleep and wakefulness will still occur.
- **Trial of treatment** – To try treatment(s) for a period of time (such as 1 or 2 weeks) until it is decided that the treatment will or will not succeed.
- **POLST – Provider Orders for Life Sustaining Treatment.** Medical orders for patients likely to be in the last year of life, containing orders (meeting form requirements for Portable DNR orders) which guide medical treatment decisions. A POLST form is intended to move with the patient between health and residential care facilities and is signed by patient and Provider.

- **Provider –** "Provider" or "Medical Care Provider" is used in this document to refer to any licensed professional providing medical, rehabilitative, or residential or custodial care under medical orders. It is important to note that the only providers authorized by law to determine a patient's capacity to make medical decisions, to recognize a surrogate, to authorize POLST or DNR orders are Medical Doctors and Advanced Practice Registered Nurses. Under Maine law, the following types of providers can do the following:
  - o Capacity determinations – physicians (DO and MD). 18-C M.R.S. § 5-909(3).
  - o Recognize medical surrogate – physicians (DO and MD). 18-C M.R.S. § 5-806
  - o Sign POLST – physician (DO or MD), APRN, PA
  - o DNR:
    - DNR Directive – physician (DO or MD), APRN, PA
    - DNR Order – physician (DO or MD)

- **Medical Surrogacy**_ Medical Surrogacy is a provision in New Hampshire statute that temporarily recognizes the authority of a relative or friend to make a patient's healthcare decisions in the absence of an advanced directive until the patient's death, or a guardian is appointed or ninety days pass, whichever is first. As noted previously, Maine has a similar statute (18-C M.R.S. § 5-806). Authority may not be extended unless the patient is "near death" and, like advance directive-appointed agents, cannot commit a patient to a psychiatric facility, or consent to sterilization, psychosurgery, electro-convulsive treatment, or an experimental treatment of any kind. Consents are limited with regard to pregnant patients. The law sets out the priority order for who may be recognized as follows:
  - (a) The patient's spouse, or civil union partner or common law spouse as defined by RSA 457:39, unless there is a divorce proceeding, separation agreement, or restraining order limiting that person's relationship with the patient.
  - (b) Any adult son or daughter of the patient.
  - (c) Either parent of the patient.
  - (d) Any adult brother or sister of the patient.
  - (e) Any adult grandchild of the patient.
  - (f) Any grandparent of the patient.
  - (g) Any adult aunt, uncle, niece, or nephew of the patient.

(h) A close friend of the patient.

(i) The agent with financial power of attorney or a conservator appointed in accordance with RSA 464-A.

(j) The guardian of the patient's estate. The individual may be named as surrogate by the provider or APRN, and authority is granted when the individual is named in the medical record. The priority order must be adhered to and the surrogate decision maker must be willing and able. A surrogate with higher priority must replace one with lower priority if found to be willing and able.

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Advance Care Planning

Important Choices with Your Care

Advance Care Planning Form

You may use this form now to tell your provider and others what medical care you want to receive if you become too sick in the future to tell them what you want. You may choose to fill out the whole form or any part of the form and then sign and date the form in Part 6.

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These are the parts:

PART 1	Fill this out if you want to choose someone to make all your health care decisions for you, either right away or if you become too sick to tell others what you want. This person is called your agent.
PART 2	Fill this out if: (1) you did not name an agent in Part 1 and now want to choose whether you want certain treatments or, (2) you did name an agent in Part 1 and want to tell your agent your wishes about certain treatments, knowing that your agent must follow your directions.
PART 3	Fill this out if you want to give the name of your primary provider.
PART 4	Fill this out if you want to make decisions about donating your organs, body or tissues after your death.
PART 5	Fill this out if you want: (1) to choose someone to make all funeral and burial decisions after your death, or (2) to tell your family any wishes you have about funeral and burial decisions.
PART 6	You must sign and date your Advance care planning form on this page. Have two witnesses sign the form at the same time you sign it. Tell others about your decisions and give copies to your provider, family and hospital.
PART 7	If you do not wish to be revived by ambulance crews should your heart or breathing stop, then you and your provider need to sign this Do Not Resuscitate (DNR) form.

Note

You may change any part of this form except for Part 6 and Part 7. You may cross out any words, sentences, or paragraphs you do not want. You can also add your own words. If you make any changes to the form, it is best if you put your initials and the date next to each change so that everyone knows it was your decision to make the change. The form lets you choose different ways to handle your care by checking boxes or filling in blanks. You may initial each box and each blank you fill in to show that it was your decision to check the box or fill in the blank.

Before filling out this form, we suggest that you talk with your lawyer, family members, providers, and others close to you about your wishes. If you make changes or complete a new form, be sure to let everyone know.

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My name (please print): _____

My address: _____

My birth date: _____

This is a list of all the people who have copies of my signed health care advance care planning:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

York Hospital Advance Care Planning Form

Part 1 – Power of Attorney for Health Care

Instructions
This part lets you choose another person to make health care decisions for you, either right away or when you are too sick to choose your own care. The person you choose is called your agent. You may also name a second and third choice to be your agent, if your first choice is not willing, reasonably available or able to make decisions for you. If you choose an agent on this form, but do not fill out any other parts of the form, your agent will be able to:

- Make all health care decisions for you, including decisions regarding tests, surgery and medication;
- Decide whether or not to have food or fluids given to you through tubes or fed into your veins through an IV
- Decide whether or not to use treatments or machines to keep you alive or to restart your heart or breathing;
- Choose who will give you health care and where you will get it, such as hospitals, nursing homes, assisted living settings, home health, or hospice care; and
- Make any health decision he or she believes would be consistent with your values or in your best interest, even if it is not listed in the form.

Who can be your agent
You can name any adult you trust to be your agent, except your agent may not be the owner, operator or employee of a nursing home or residential long-term care facility where you are receiving care, unless that person is your relative.

How your agent must make decisions
If your agent does not know what you want, the agent must make decisions consistent with your personal values, if known, or based on your best interests. In Part 2, you can decide what you want in advance. If you make choices in Part 2, your agent must make decisions based on those choices.

Who can see your health care information
Once your agent has the right to make health care decisions for you, your agent can look at your medical records and consent to giving your medical information to others. The state and federal privacy laws let your agent see all of your health information so that he or she can make the right decision for you.

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Choosing an agent

Fill in your name and the name of the person you choose to be your agent to make health care decisions for you here:

My name (please print): _____

My address: _____

My birth date: _____

My agent's name _____

Title or relationship to me _____

My agent's address _____

My agent's home phone (___) _____ My agent's work phone (___) _____

My agent's email address _____

If the agent I have named above is not willing, reasonably available or able to make decisions for me, I choose the following person to be my agent:

Choice #2 to be my agent

Name _____

Title or Relationship to Me: _____

Address: _____

_____

Home phone (___) _____

Work phone (___) _____

Email Address: _____

If the person I have named as Choice # 2 is not willing, reasonably available or able to make decisions for me, I choose the following person to be my agent:

Choice #3 to be my agent

Name _____

Title or Relationship to Me: _____

Address: _____

_____

Home phone (___) _____

Work phone (___) _____

Email Address: _____

You may change your mind later about who you want to be your agent. If you want to stop the agent you have named from making decisions for you, you must tell your primary provider or fill in these blanks

I do NOT want _____ to be my agent _____

My signature

Date you filled out this section _____

Any time you cancel, replace or change this form you should give copies of the changed or new form to everyone who has a copy of your original form.

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Your Agent's Power:

When your agent can start making decisions for you: (Check only one box: A or B)

A. ☐ My agent can make decisions only when my primary provider or a judge decides that I am too sick to make my own health care decisions.

~OR~

B. ☐ My agent can start making health care decisions for me right away, but this does not mean I have given up the right to make my own decisions if I am still able and willing to make my own decisions. When my agent makes a health care decision for me, I will be told, if possible, about that decision before it is carried out unless I say I do not want to know. If I disagree with that decision and am still able to decide, I can make a different decision. As long as I am able, I can end my agent's right to make decisions for me, change my agent or make my own decisions. If I want to end my agent's right to make decisions for me, I must tell my primary provider or put my decision in writing and sign it with the date of my signature.

Nominating a guardian: A guardian is a person chosen by a court to make decisions about your personal care. These decisions can include not only health care, but other decisions such as where you will live and how your personal needs will be met. If you wish, you may ask that a court assign your agent as your guardian, if appointment of a guardian should become necessary. Check the box below to nominate your agent to be your guardian, if a judge needs to appoint a guardian for you.

☐ I nominate my agent to be my guardian if a judge needs to appoint a guardian for me.

If you want to nominate someone other than your agent to be your guardian, you may fill in the section below.

If a judge needs to appoint a guardian for me, I nominate the person named below as my guardian:

Name_____

Title or relationship to me _____

Address_____

_____

Home phone (____) _____

Work phone (____) _____

York Hospital Advance Care Planning Form

Part 2 – Special Instructions

Instructions if you did NOT name an agent in Part 1:

If you did not name an agent in Part 1, you should fill out this Part to state what you want for care if you become too sick to make your choices known.

~OR~

Instructions if you did name an agent in Part 1:

If you named an agent in Part 1, you do not have to fill out this part of the form. If you want your agent to make all of your health care decisions, DO NOT fill out this part of the form. Your agent will make decisions in your best interests, including decisions to refuse treatment. However, you may fill out this part if you want to give special directions to your agent about your wishes, such as when you are near death, in a permanent coma or no longer able to make your own decisions. You may also cross out or add words. It is best if you put your initials and date next to any changes you make so everyone knows the changes were your decision. If you complete this part, your provider and others will follow these instructions and your agent cannot make a different decision. You may also write your wishes on another piece of paper, sign it, date it, and keep it with this form.

Life-Sustaining Treatment Choices:

You may also check one of the two boxes below to show your choice about treatment that would keep you alive:

☐ **Choice not to be kept alive**

I do not want treatment to keep me alive if my provider decides that either of the following is true;

(i) I have an illness that will not get better, cannot be cured, and will result in my death quite soon (sometimes referred to as a terminal condition),

~OR~

(ii) I am no longer aware (unconscious) and it is very likely that I will never be conscious again (sometimes referred to as a persistent vegetative state).

☐ **Choice to be kept alive**

I want to be kept alive as long as possible within the limits of generally accepted health care standards, even if my condition is terminal or I am in a persistent vegetative state.

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Life-Sustaining Treatment Choices:

You may also check one of the two boxes below to show your choice about treatment that would keep you alive if, in the future, you have late stage Alzheimer's disease or other severe dementia. These choices will not limit the authority under state law for your agent, surrogate, guardian or provider to make treatment choices if you are unable to make your own decisions and are not in late stage Alzheimer's disease or other severe dementia:

☐ **Choice not to be kept alive**

If my provider and a second provider decide that I am in the late stage of Alzheimer's disease* or other severe dementia, I do not want treatment to keep me alive.

☐ **Choice to be kept alive**

I want treatment to keep me alive as long as possible within the limits of generally accepted health care standards, even if my provider and a second provider decide that I am in the late stage of Alzheimer's disease or other severe dementia.

*Only a provider can determine that someone is in the late stage of Alzheimer's disease. People in the late stages of Alzheimer's disease generally have a number of the following characteristics: loss of the ability to respond to their environment; loss of the ability to speak; loss of the ability to control movement; loss of the capacity for recognizable speech, although words or phrases may occasionally be uttered; needing help with eating and toileting; general incontinence of urine; loss of the ability to walk without assistance, then the ability to sit without support, then the ability to smile, and the ability to hold their head up; reflexes become abnormal; muscles grow rigid; and swallowing is impaired.

Tube Feeding:

You may check one of the two boxes below to show your choice about tube feeding or having water and nutrition fed into your body through an IV or tube (artificial nutrition and hydration):

☐ **Artificial nutrition and hydration should not be given, or should be stopped, based on the other life-sustaining treatment choices I made about keeping me alive on Pages 6 and 7.**

☐ **Artificial nutrition and hydration should be given regardless of my condition.**

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Relief from Pain:

You may check the box or fill in the blanks below to show your choice about relief of pain or discomfort.

☐ **I want treatment for relief of pain or discomfort to be given at all times, even if it shortens the time until my death or makes me drowsy, unconscious or unable to do other things.**

These are my wishes about relief of pain or discomfort:

Other Directions:

You may give more directions or add any other treatment choices in the space below:

York Hospital Advance Care Planning Form

Part 3 – Primary Provider

This section is optional. Fill out this part only if you wish to name your primary provider today. This may or may not be your established PCP.

Name of my primary provider:_____

Address_____

Phone _____

I want any agent I named in Part 1 to talk with this provider about my health care. If the provider I have named above is not willing, reasonably available or able to carry out my wishes, I want the agent I named in Part 1 to talk with the provider listed below:

Name of provider:_____

Address_____

Phone _____

York Hospital Advance Care Planning Form

Part 4 – Donation of Body, Organs or Tissues at Death

This section is optional. Fill out this part only if you want to give directions about donating your body, organs or tissues after your death.

☐ I do NOT wish to donate any organs, tissues or parts.

I have checked below my choices about donating my body, organs or tissues after death. I have spoken with my family so that they will not object to my wishes after I die.

☐ I give my body. **OR**

☐ I give any needed organs, tissues or parts. **OR**

☐ I give only the following organs, tissues, or parts:

_____

_____

My gift is for the following purposes (you may check any number of boxes):

☐ My gift is for transplant or therapy for another person, to be chosen based on generally accepted health care standards.

☐ My gift is for research and education. My preference, if any, is to give my body, organs, or tissues to the following hospital, medical school, or provider:

Name:_____

Address_____

_____

_____

I understand that I may need to contact the hospital, medical school, or provider before I die in order for them to accept my body, organs or tissues after my death.

York Hospital Advance Care Planning Form

Part 5 – Instructions About Funeral and Burial Arrangements

This section is optional. Fill out this part only if you wish to give special instructions about your funeral or burial arrangements here.

I hope that my family will follow my wishes after I die as noted below.

☐ **I choose_____ to have custody and control of my body after my death with the right to decide everything about my funeral and burial.**

OR

☐ **I want my family to know these are my wishes about: burial, cremation, funeral, or memorial service. (Fill in)**

_____

_____

_____

_____

_____

_____

If you plan to die at home, talk with your provider and funeral director about your plans. When you die, your family or agent should call your provider and the funeral home you have chosen. The funeral home staff will pick up your body from your home.

York Hospital Advance Care Planning Form

Part 6 – Signing the Form

If you have filled out any part of this form, you must sign and date the form on this page. You must also have two other adults sign as witnesses at the same time you sign the form. Your agent cannot sign as a witness. You do not need to have a Notary Public sign your Advance care planning form to make it legal in Maine. However, if you travel or live part of the year out-of-state, it would be wise to have it signed by a Notary. Some states require this. You can find this service under Notary Public in the phone book. Most banks also have Notaries Public and will usually notarize papers for bank customers when asked. The Notary Acknowledgment may be done at any time after you sign this form.

If you are a Maine resident and if you are in a hospital or residential healthcare facility, have an infectious disease and are confined to a room or ward where isolation precautions prevent the physical presence of individuals or documents necessary for filling out and signing this form, you may be able to complete the form using audiovisual technology. You can find details on that process at 18-C M.R.S. § 5-803-A,located at **https://legislature.maine.gov/statutes/18-C/title18-Csec5-803-A.html.**

Sign and date the form here:

Sign your name:_____ Date:_____

Print your name:_____ Your address:_____

_____

First Witness:

Sign your name:_____ Date:_____

Print your name:_____ Your address:_____

_____

Second Witness:

Sign your name:_____ Date:_____

Print your name:_____ Your address:_____

_____

Notary Acknowledgment.

Then personally appeared the above named_____, known to me or who presented satisfactory evidence of his/her identity, and acknowledged this Advance care planning as his/her free act
and deed before me.

Notary signature:_____Date:_____

Printed name: _____ Notary Public State of _____Commission Exp.:____

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Make sure to tell people.

Tell your family members, providers and ot hers close to you what you have decided.You should talk to the agent(s) you have chosen to make sure that they understand your wishes and are willing to carry them out. Give a copy of this form to your provider, to any place where you get health care, and to any**agent(s) you have chosen in Part 1. Please be sure to list the people who have copies of this form on the front page.**

Canceling or changing the form.

Part 1: You may end your agent's right to make decisions while you are still able to make those decisions by telling your primary provider or putting your decision in writing and attaching it to this form. If you want to name a new agent, you must put that instruction in writing and sign it in front of two witnesses who must also sign their names.

Parts 2–7: You may cancel any other part of this form, or change your instructions in the other parts of this form while you are still able to make those decisions. It is best to do so by (1) writing on this form, (2) writing on another piece of paper and attaching it to this form, or (3) completing a new form. Any of those written changes should be signed and dated by you.

York Hospital Advance Care Planning Form

Part 7 – Instructions to Emergency Medical Services (Ambulance Crews) About What to Do if Your Heart or Breathing Stops.

This section is optional. If you do not want ambulance crews to revive you if your heart or breathing stops, you and your provider must both complete and sign this part.

Instructions for Part 7:

- If I stop breathing or my heart stops, I do not want the Emergency Medical Services (ambulance crews) to try to revive me. My provider and I have discussed this and signed the special form on the next page. I understand that this decision will not prevent me from receiving other emergency care, or comfort care from health care workers before I die.
- I understand that the form goes into effect when I have signed it AND it is signed by my provider.
- I understand that this directive will not be followed unless my family, caretaker or I give the signed form on the next page to Emergency Medical Services (ambulance crews), and that it is solely my responsibility to make sure they see it.
- I understand that I should carry the signed form with me unless I wear health alert jewelry, such as MedicAlert, that also tells people that I do not want to be revived if my heart or breathing stops (Please call Maine Emergency Medical Services at 207-626-3860 to see if there are other Maine EMS approved health alert jewelry companies).
- I understand that if any health care provider has any doubts about what I want, they will try to restart my heart or breathing.
- I understand that I may revoke this directive at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry. I can also tell the ambulance crews that I have changed my mind.
- I understand that should I change my mind, it is my responsibility to tell my provider and other people who have copies of the signed form. If I want my agent to make this decision later, my agent should take the form available at: http://www.maine.gov/dps/ems to my provider when it is time to make the decision.

If you complete and sign this section, put the original in a safe place and be sure to give copies to ambulance crews, your family, your caregivers, and your provider.

York Hospital Advance Care Planning Form

DO-NOT-RESUSCITATE (DNR) DIRECTIVE

This section is optional. If you do not want ambulance crews to revive you if your heart or breathing stops, you and your provider must complete and sign this form.

FOR PATIENT TO COMPLETE after consultation with his or her health care provider:

In the event that my heart or breathing stops and I am unable to speak for myself, I, _____ (printed name) direct that no efforts be taken to restart my heart or breathing and that Emergency Medical Services (ambulance crews) if notified, honor my directive. I have come to this decision after considering my condition and prognosis and the potential risks, burdens and benefits of refusing efforts to restart my heart or breathing.

I understand that I may change my mind at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry, such as MedicAlert. I will also tell my provider and other caregivers if I change my mind.

I understand that this form is not valid until my provider and I have signed it.

I understand that in a hospital, nursing home, hospice or home health setting, federal law requires that my provider must include a specific DNR order in my medical record or plan of care, even if we have both signed this form.

☐ No expiration date OR ☐ Expires on _____

Patient Signature _____Date Signed_____

FOR PROVIDER TO COMPLETE:

By my signature I affirm that:

(i) After meeting with this patient and discussing this decision, I am satisfied that the patient understands the potential risks, burdens and benefits of refusing resuscitative interventions in light of the patient's medical condition; and (ii) I believe that the patient has made a voluntary informed decision about resuscitation and I agree to comply with that decision. I will tell any health care providers providing care under my authority to comply with this decision.

Signature and license level (MD, DO, PA or NP):

_____Date Signed_____

Printed Name _____Telephone Number_____

THIS FORM IS ENDORSED BY MAINE EMERGENCY MEDICAL SERVICES

York Hospital Advance Care Planning Form

Notes

York Hospital Advance Care Planning Form

Notes

Advance Care Planning
Important Choices with Your Care

Remember, we are here to help you and your loved ones in this process. For more information:

- Visit **www.yorkhospital.com/care-management**
- Call Care Management at (207) 351-2226
- Contact the Health Care Help Center at (207) 351-2345
- The Center for Older Adults can be reached at (207) 351-2371
- Contact your primary care provider
- Contact Spiritual Care at (207) 361-3647

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