Durable Power of Attorney for Health Care Decisions

General Statement of Authority Granted

I, _____ designate and appoint:

Name _____

Address _____

_____

Telephone Number _____

to be my agent for health care 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 health care 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 health care 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 health care 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 health care 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 health care decisions shall be subject to the additional following limitations:

_____

_____

(continued from previous page)

Effective Time

This durable power of attorney for health care 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).*

Revocation

Any durable power of attorney for health care decisions I have previously made is hereby revoked. (This durable power of attorney for health care 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 health care; OR (2) acknowledged by a notary public.

_____ Witness	_____ Witness
_____ Address	_____ Address

(OR)

STATE OF _____

COUNTY OF _____

This instrument was acknowledged before me on _____
(Date)

by _____
(Name of Person)

_____
(Seal, if any) (Signature of Notary Public)

My appointment expires _____

This declaration may be revoked or changed by declarant at any time.

Living Will
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.

My additional instructions, if any, are listed on the reverse side.

Signed _____
(Declarant)

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 18 or older, not related to the declarant by blood or marriage, not entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of the declarant or codicil thereto, and not directly financially responsible for declarant's medical care.

_____ Witness

_____ Witness

_____ Address

_____ Address

(OR)

STATE OF _____ COUNTY OF _____

This instrument was acknowledged before me on _____ by _____

_____
(Signature of Notary Public)

(Seal, if any)

My appointment expires _____

This declaration and optional additional instructions may be revoked or changed by declarant at any time.

(continued from previous page)

Optional Additional Instructions

I make these optional additional instructions to my living will to exercise my right to determine the course of my health care and to provide clear and convincing proof of my treatment decisions **when I lack the capacity to make or communicate my decisions**.

If there is a phrase, statement or section below with which you do not agree, draw a line through it and add your initials.

- I direct all life-prolonging procedures be withheld or withdrawn when there is no hope of significant recovery, and I have:
  - a terminal condition; or
  - a condition, disease or injury without hope of significant recovery and there is no reasonable expectation that I will regain an acceptable quality of life; or
  - substantial brain damage or brain disease which cannot be significantly reversed; or
  - other _____
- I choose to have withheld or withdrawn the following life-prolonging procedures, when the above conditions exist:
  - surgery
  - heart-lung resuscitation (CPR)
  - antibiotics
  - mechanical ventilator (respirator)
  - dialysis
  - tube feedings (food and water delivered through a tube in the vein, nose or stomach)
  - other _____
- If my physician believes that a certain life-prolonging procedure or other health care treatment may provide me with comfort, relieve pain or lead to a significant recovery, I direct my physician to try the treatment for a reasonable period of time. However, if such treatment proves to be ineffective, I direct the treatment be withdrawn even if so doing shortens my life.
- I direct I be given health care treatment to relieve pain or to provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.
- I make other instructions as follows: (you may want to describe what an acceptable quality of life is)

_____

_____

- I have discussed my wishes with the following person(s) and authorize my physician to discuss my treatment and this document with them: **(if you have used a Medical Durable Power of Attorney to appoint an agent, initial here _____ and include that person on the first line below.)**

Name (Agent)	Address	Telephone
Name	Address	Telephone

I have read these instructions and have given them careful consideration. As I have indicated, they are in accordance with my wishes.

Date _____ Signed _____

_____ Witness

_____ Witness

Do Not Resuscitate
Prehospital DNR Request Form
An Advanced Request to Limit the Scope of Emergency Medical Care

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

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 prehospital 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 prehospital care providers, doctors, nurses, or other health care personnel as necessary to implement this directive.

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

_____ _____
Signature Date

Witness:*

_____ _____
Witness Date

_____
Address

*Must be 18 or older, not related to the declarant by blood or marriage, not entitled to any portion of the declarant's estate according to Kansas laws of intestate succession or under any will of the declarant or codicil thereto, and not directly financially responsible for the declarant's medical care expenses.

Attending Physician:* 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 is 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

Where Personal and Property Records are Kept

Record	Where Kept
Marriage Records/Divorce Papers	
Birth Certificates/Adoption Papers	
Wills/Advance Directives/Durable Powers of Attorney	
Baptismal Records	
Death Certificates	
Citizenship Papers/Tribal Enrollment Record	
Social Security	
Military Service Records (including military discharge and service number)	
Passports	
Immunization Records	
Deeds to Property	
Where is Deed Recorded?	
Deed to Cemetery Lot	
Abstract to Title of Property/Title Insurance	
Mortgage Papers	
Automobile Title and Bill of Sale	
Household Inventory	