INSTRUCTIONS

PRINT YOUR NAME

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR AGENT

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST AND SECOND ALTERNATE AGENTS

Part One. Medical Durable Power of Attorney

I, _____, hereby
(your name)
appoint:

_____
(name of agent)

_____
(home address of agent)

_____
(work telephone number) (home telephone number)

as my agent to make health care decisions for me if and when I do not have the capacity to make my own health care decisions. This gives my agent the power to consent to giving, withholding or stopping any health care, treatment, service, or diagnostic procedure. My agent also has the authority to talk with health care personnel about my condition, access my medical records, get information and sign forms necessary to carry out those decisions. If the person named as my agent is not available or is unable or unwilling to act as my agent, then I appoint the following person(s) to serve in the order listed below:

1. _____
(name of first alternate)

_____
(home address)

_____
(work telephone number) (home telephone number)

2. _____
(name of second alternate)

_____
(home address)

_____
(work telephone number) (home telephone number)

By this document I intend to create a Medical Durable Power of Attorney which shall take effect upon my incapacity to make my own health care decisions and shall continue during that incapacity.

When making health care decisions for me, my agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in Part Two (if I have filled out Part Two), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

(a) Additional Instruction:

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

INSTRUCTIONS

PRINT YOUR NAME

INITIAL ONLY ONE OPTION THAT REFLECTS YOUR WISHES

IF YOU INITIAL THE SECOND CHOICE, YOU MUST CHOOSE THE NUMBER OF DAYS YOU WANT LIFE-SUSTAINING PROCEDURES CONTINUED

Part Two. Declaration

I, _____,
(name)

being of sound mind and at least eighteen years of age, direct that my life shall not be artificially prolonged under the circumstances set forth below and hereby declare that:

If at any time my attending physician and one other qualified physician certify in writing that:

a. I have an injury, disease, or illness which is a terminal condition for which the administration of life-sustaining procedures will only serve to prolong the dying process and I am unable to make health care decisions, or

b. I am in a persistent vegetative state,

I direct that, in accordance with Colorado law, life-sustaining procedures shall be (Initial only the option that applies)

_____ (Initials) I direct that life-sustaining procedures shall be withdrawn and/or withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nourishment considered necessary by the attending physician to provide comfort or alleviate pain.

_____ (Initials) I direct that life-sustaining procedures shall be continued for a period of not less than _____ days, and if there be no change in my condition which would indicate to my physicians that my prognosis has improved, then I direct that life-sustaining procedures shall be withdrawn and/or withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nourishment considered necessary by the attending physician to provide comfort or alleviate pain.

_____ (Initials) I direct that life-sustaining procedures shall be continued indefinitely, regardless of my prognosis.

INITIAL ONLY ONE

IF YOU INITIAL THE SECOND CHOICE, YOU MUST CHOOSE THE NUMBER OF DAYS YOU WANT ARTIFICIAL NOURISHMENT CONTINUED

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

In the event that the only procedure I am being provided is artificial nourishment, I direct that one of the following actions be taken: (initial the option that applies)

_____ (Initials) Artificial nourishment shall not be continued when it is the only procedure being provided; or

_____ (Initials) Artificial nourishment shall be continued for _____ days when it is the only procedure being provided; or

_____ (Initials) Artificial nourishment shall be continued indefinitely when it is the only procedure being provided.

I further direct that:

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 agent (if any), 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.

Part Three. Execution.

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature:_____

Date:_____

Address:_____

WITNESSING PROCEDURE

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES

WITNESSES

I declare that the person who signed or acknowledged this document ("the patient") is personally known to me, that he/she signed or acknowledged this Advance Medical Directive in my presence, and that he/she appears to be of sound mind and under no duress, fraud or undue influence. I did not sign this document for the patient. I am not the person appointed as the agent by this document. I am not a physician, nor am I the patient's health care provider, or an employee of the patient's health care provider. I have no claim on, nor am I entitled to, any portion of the patient's estate.

WITNESS #1

First Witness' Signature_____

Date_____

Print Name _____

WITNESS #2

Second Witness' Signature_____

Date_____

Print Name _____

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

COLORADO ORGAN DONATION FORM - PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under Colorado law.

_____ I do not want to make an organ or tissue donation and I do not want my attorney for health care, proxy, or other agent or family to do so.
_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____ Pursuant to Colorado law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature: _____, Date: _____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____

_____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness _____Date_____

Address _____

_____

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