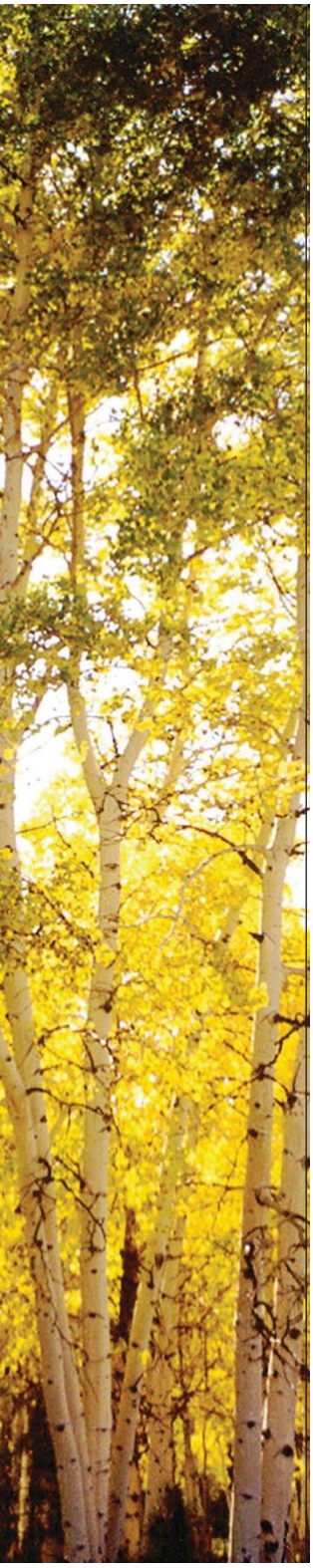
Name: _____Date of Birth: _____



Advance Care Planning Packet

Northern Arizona Healthcare is committed to respecting our patients and their choices. Patient choice is vital to everyday healthcare decisions. Your healthcare team needs to know what is important to you in order to make a plan that ensures honor, respect and dignity in regards to medical decisions. Advance care planning also tells your medical team who should be involved in your care and who should be called upon in your time of need.

NAH understands that these questions and conversations may be difficult; and they may require time and cultural considerations. However, going through this process ahead of time can lessen the stress on your family in the event of serious illness.

Start the conversation now: Consider which of your loved ones to include in your decision-making process, as well as which members of your healthcare team.

The following questions may help start the conversation:

1. Do you have any significant medical problems or other problems? What are your worries about medical treatment?

2. How do your culture, faith and spirituality play a role in your life and healthcare decisions?

3. What are your worries about money and how your financial situation may impact your health care decisions?

4. If you knew time was short, what would be important to you to do or say? Are there any situations in which you would want to shift the focus from cure to comfort?

5. If you were so sick that you were not able to speak for yourself, who would your doctors talk to about medical decisions? (This person is typically a trusted individual who is over the age of 18, and who is willing to accept the responsibility of honoring your choices.)

Name: _____Date of Birth:_____

Healthcare (Medical) Power of Attorney with Mental Health Authority

If I am unable to communicate my wishes and healthcare decisions due to incapacitation, or my doctor determines that I am not able to make my own healthcare decisions, I appoint the following person (hereafter referred to as "healthcare power of attorney" or "healthcare agent") to represent my choices and healthcare decisions. (If you **DO NOT** choose someone to make decisions for you, write **NONE** in the line for the agent's name).

My healthcare power of attorney will make choices for me about my medical care, including limitations to life-prolonging treatment. My healthcare power of attorney will interpret any instructions I have given in this form according to his/her understanding of my wishes, values and beliefs. My healthcare power of attorney will review and release my medical records as needed for my medical care (Health Insurance Portability and Accountability Act of 1996). **By initialing below:**

_____ I specifically consent to give my healthcare agent the power to admit me to an inpatient or partial psychiatric hospitalization program if ordered by my physician.

_____ This Advance Directive (Living Will), with Healthcare Power of Attorney with Mental Health Authority, may NOT be revoked if I am incapacitated.

My healthcare agent is:

Name:_____Relationship:_____

Telephone (h):_____ Telephone (c): _____

Address: _____

My alternate agent is:

Name: _____ Relationship: _____

Telephone (h):_____ Telephone (c):_____

Address: _____

Sign here for the Advance Directive and Healthcare Power of Attorney Forms:

Please ask two individuals to witness your signature who are not related or financially connected to you.

Signature/Print:

_____Date:_____

Witnesses: I personally witnessed the signing of this document. I certify that I am not appointed as healthcare agent in this document. If I am a healthcare provider or an employee of a healthcare provider, I certify that I am not providing direct care to this individual.

Witness Signature/Print: _____Date:_____

Witness Signature/Print: _____Date:_____

This document may be notarized instead of witnessed.

On this _____day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS THEROF, I have set my hand and affixed my official seal in the County of _____, State of _____, on the date written above.

Notary Public_____

My Commission expires: _____

Name: _____Date of Birth:_____

Advance Directive (Living Will)

I, _____ have completed this document to provide information to my healthcare team to assist in difficult decisions regarding my medical treatment. **I have initialed my choice below.**
_____I want my life to be prolonged to the greatest extent possible until my doctor confirms that such treatments are no longer helpful or my condition is irreversible.

I want to stop or withhold treatments that prolong my life and to focus on comfort if any of the following persistent events occur:
☐ I am in chronic coma or persistent vegetative state.
☐ I am unable to communicate my needs.
☐ I have total or near total dependence on others for care.

☐ **Pregnancy:** If I am known to be pregnant at any time, I would like my Advance Directive to remain valid.

_____If I have a terminal condition, I DO NOT want my life to be prolonged and I DO NOT want any life-sustaining treatment beyond comfort care.

Check the treatments below that you DO NOT want under any circumstances:
☐ Ventilation support (breathing machine)
☐ Artificial nutrition: Food and water by a feeding tube or intravenously
☐ Dialysis
☐ Other:_____

Cardiopulmonary Resuscitation (CPR)
_____ I DO NOT want CPR attempted if my heart stops or breathing stops. I want to allow a natural death.

_____ I want CPR attempted if my heart or breathing stops.

Information I would like my healthcare provider to know (funeral arrangements, burial preferences, etc.):
_____
_____
_____

Sign here for the Advance Directive and Healthcare Power of Attorney Forms:

Please ask two individuals to witness your signature who are not related or financially connected to you.
Signature/Print:
_____Date:_____

Witnesses: I personally witnessed the signing of this document. I certify that I am not appointed as healthcare agent in this document. If I am a healthcare provider or an employee of a healthcare provider, I certify that I am not providing direct care to this individual.
Witness Signature/Print: _____Date:_____

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This document may be notarized instead of witnessed.
On this _____day of _____, in the year of _____, personally appeared before me the person signing, known by me to be the person who completed this document and acknowledged it as his/her free act and deed. IN WITNESS THEROF, I have set my hand and affixed my official seal in the County of _____, State of _____, on the date written above.
Notary Public_____
My Commission expires: _____

Please provide a copy of this form to the hospital and your healthcare team. You can cancel or change this form at any time.

Northern Arizona Healthcare
NAHealth.com

NAH Hospital/Forms Approved by DCC 10/9/2013, Rev. 8/23/2016