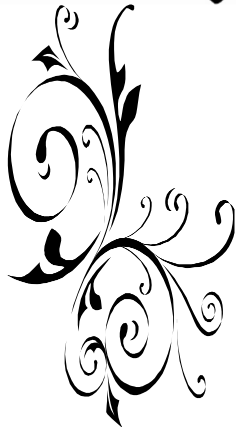


PLANNING FOR HEALTH CARE DECISIONS:

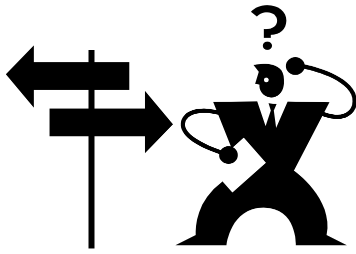
Informed Consent

Power of Attorney for Health Care

Living Will (End-of-Life Decisions)

Organ Donation

Comfort One - DNR/CPR Directive



Planning for Health Care Decisions has many parts that you should know about before making decisions about you medical care or treatment.

Patient Rights:

MHSC supports your right to make informed decisions and give *"informed consent".*

MHSC supports and facilitates patient involvement in decisions about care, treatment and services provided:

• You have a right to be involved in decisions about your care, treatment and services.
• Your surrogate decision maker, as allowed by law, will be identified when you cannot make decisions about your care, treatment and services. This legally responsible representative will approve care, treatment and service decisions on your behalf.
• Your family, as appropriate and as allowed by law, with your permission or the permission of your surrogate decision maker, has the right to be involved in care, treatment and service decisions.

*A **Power of Attorney for Health Care** is a form that allows you to name someone to act as your "agent" in making health care decisions if you are unable to make your own decisions.*

MHSC supports your right to refuse care, treatment and services in accordance with law and regulation. When you are not legally responsible, MHSC supports your right to address end-of-life your surrogate decision maker has the right to refuse on your behalf.

MHSC supports your right to address end-of-life decisions:

• You have the right to review and revise your advanced directives. If you do not have an advanced directive, assistance will be available to formulate one.
• The hospital will honor your advanced directive within the limits of the law and the hospital's capabilities.
• The hospital will honor you wishes concerning organ donation within the limits of the law and the hospital's capabilities.

*To prevent the use of treatments you do not want, you can fill out a form called and **"Advance Health Care Directive".***

Advance Health Care Directive

http://www.health.wyo.gov/aging/resources/advance.html

What does a Health Care Advance Directive do?

The Wyoming Advance Health Care Directive is a legal document that allows you to:

- Name an agent to make health-care decisions for you if you become incapable of communicating or making your own decisions
- Name an alternate agent in case your first choice is not able, willing, or reasonably available, to make decisions for you
- Designate the level of decision-making power of your agent(s)
- Nominate a person to act as your guardian if a court determines that you need one
- Give specific instructions on whether to continue, withhold or withdraw treatment, including nutrition and hydration, as well as pain relief
- Express whether you wish for your organs and/or tissue to be donated upon your death
- Designate a supervising primary health-care provider to have primary responsibility for your care

What does this replace?

The attached form has the potential to take the place of a Living Will, a Durable Power of Attorney for Health Care and an Organ Donation designation. If you have completed these forms already, you may still want to fill out the attached form to ensure that your wishes are adequately recorded, and will be honored while you are in the state of Wyoming.

Documents completed and properly executed ***before*** the Wyoming Advance Health Care Directive became available on July 1, 2005, ***will remain valid,*** but this is a good time to review the documents you already have in place.

If you complete the attached document, please destroy any old documents to avoid confusion. Notify your designated agent, family, friends, your physician and your local hospital of your new advance directive.

When does a Health Care Advance Directive go into effect?

It is valid once you, your witnesses, and/or a notary public sign it. It will not take effect until you are unable to make your own medical decisions, and when your doctor has determined that you are terminally ill, or that you are in a permanent unconscious state. ***This new directive allows you to designate a different way to determine incapacity, and it also allows you to put the directive into effect immediately upon completion if you wish to have someone else take over as your agent now.*

"Do Not Resuscitate" (DNR)

Is a Health Care Advance Directive the same as a "Do Not Resuscitate" (DNR) order?

No. A Health Care Advance Directive covers almost all types of life-sustaining treatments and procedures and is put into place if you have a terminal condition or in a permanent unconscious state. The Health Care Advance Directive is suspended during emergency medical care, whether provided by an emergency medical technician, an emergency room physician, or by a similar health-care provider. Emergency responders in Wyoming are required to provide Cardio-Pulmonary Resuscitation (CPR), unless they are given a specific written "Do Not Resuscitate" (DNR) order. Once you are in the care of a primary attending physician, your Advance Directive resumes.

A DNR order is a document prepared by your doctor and filed with the state of Wyoming at your direction. This DNR is called a ***"Comfort One."*** It states that if you suffer cardiac arrest, (your heart stops beating) or respiratory arrest, (you stop breathing), your health care providers, (including emergency personnel), are not to try to revive you by any means.

Comfort One

COMFORT ONE® is the name of a statewide program designed to allow a Wyoming citizen to refuse cardio-pulmonary resuscitation (CPR) in Wyoming. The program is administered through the Wyoming Department of Health, Office of Emergency Medical Services Programs. Historically, when ambulance personnel were dispatched, emergency responders were obligated to initiate full resuscitation, whether or not resuscitation was desired by the patient or their family. Furthermore, unless special arrangements were made, standard Do Not Resuscitate (DNR) orders for other advance directives were not generally honored in an emergency situation outside of the hospital. The program, originally implemented to alert emergency ambulance personnel that an individual was "DNR", Comfort One® is now recognized by itself or in conjunction with a properly executed Living Will or Durable Power of Attorney for Medical Decisions.

Wyoming legislation enacted in 1993 provides health professionals with the authority to withhold CPR when the proper documentation is on file with the Department of Health's Office of Emergency Medical Services Programs.

A special bracelet, which is a simple gold chain with the words "Comfort One®" etched onto a single green disc, is provided to applicants after the proper paperwork is completed and submitted to the office. Interested individuals must complete and sign an application form which also requires the signature of their physician, return the completed form to the Emergency Medical Services Programs office, along with $25.00, a fee which covers only the cost of the bracelet. Each bracelet is numbered and a specific number is assigned to each individual. Participants also receive a copy of the application which clearly states they are a Comfort One® participant.

The decision to participate in the Comfort One® program requires very careful thought and serious discussion with one's family, clergy and physician. It should be noted also that an individual can elect to have their Comfort One® status revoked at any time by providing written notice as soon as practical to the EMS, the attending physician, and to those who have actual notice of the CPR directive

To request a Comfort One application, please call the EMS Office toll free at 888 228-8996 (in Wyoming only) or 307-777-7955. The application may be obtained on request by writing to:

Wyoming Office of Emergency Medical Services, Attn. Comfort One, Hathaway Building, 4th Floor, Cheyenne, WY 82002

The Comfort one Application packet may be obtained be emailing Beth Hollingworth, Comfort One Coordinator at Beth.Hollingworth@health.wyo.gov

When emailing the request for a Comfort One packet, please provide: Name, mailing address, city and zip code.

The Comfort One application is not available for download due to needing signatures on a 5 part form.

Wyoming Advance Health Care Directive Form

Part 1 – This section of the form is a Power of Attorney for Health Care. Part 1 lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now, even though you are still capable. Unless the form you sign limits the authority of your agent, your agent may make all health care decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all health care decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

- Consent or refuse to consent to any care, treatment, service or procedure that is meant to maintain, diagnose or otherwise affect a physical or mental condition.
- Select or discharge health care providers and institutions.
- Approve or disapprove diagnostic tests, surgical procedures, medications and orders not to resuscitate.
- Direct the provision, withholding or withdrawal of artificial nutrition and hydration, and all other forms of health care.

Part 2 – The second section of this form lets you give specific instructions about any aspect of your health care. Choices are provided for you to express your wishes regarding the provision, withholding or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made, or for you to write out any additional wishes.

Part 3 – The third section of this form lets you express an intention to donate your bodily organs and tissues following your death.

Part 4 – The final section of this form lets you designate a supervising health care provider to have primary responsibility for your health care.

After completing this form, sign and date it at the end. This form must either be signed before a notary public **or, in the alternative,** be witnessed by two (2) witnesses. *(See form for guidelines on who can/cannot witness your document.)*

Remember to talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You should keep your Health Care Advance Directive in a safe place where your family members can get to them. Do **NOT** keep the original copies in your safe deposit box. Give copies of these documents to as many of the following people as you are comfortable with: your spouse and other family members, your doctor, your lawyer, your clergyperson, and any local hospital or nursing home where you may be residing. Another idea is to keep a small card in your purse or wallet which states that you have an advance directive and who should be contacted.

You have the right to revoke this Advance Health Care Directive or replace this form at any time.

1) The Power of Attorney for Health Care portion of the directive can be revoked by signing a written notification to the agent or by personally notifying the designated supervising primary health care provider.
2) In the event of a legal separation, annulment or divorce, a power of attorney that designates a spouse as an agent is automatically revoked.
3) Other portions of the directive may be changed or revoked in any manner that communicates your wishes.

Frequently asked questions and answers

1) **Do I have to have a Health Care Advance Directive?**
   No, it is entirely up to you whether you want to prepare any documents. But if questions arise about the kind of medical treatments that you want, or do not want, an advance directive may help to solve these important issues.

2) **What will happen if I do not make a Health Care Advance Directive?**
   You will receive medical care even if you do not have any advance directives. However, there is a great chance that you will receive more treatment or more procedures than you may want.
   If you cannot speak for yourself and you do not have any advance directions, your doctor or any other health care provider will look to the following people in the order listed for decisions about your care:
   1) Your spouse, unless you are legally separated; 2) any of your adult children; 3) either of your parents 4) any of your grandparents 5) any of your adult brothers or sisters 6) any of your adult grandchildren 7) any other adult who has exhibited special concern for you and who is familiar with your personal values.

3) **Whom should I talk to about Health Care Advance Directives?**
   Talk to the people closest to you and who are concerned about your care and feelings. Discuss this issue with your doctor, friends, and other appropriate people, such as a member of your clergy or your lawyer. These are the people who will be involved with your health care if you are unable to make your own decisions.

4) **Will my Health Care Advance Directive be followed?**
   Generally, yes, if they comply with Wyoming law. It may happen that your doctor or other health care provider cannot, or will not follow your Advance Directives for moral, religious or professional reasons, even though they comply with Wyoming law. If this happens, they must immediately tell you. Then they must help you transfer to another doctor or facility that will do what you want.

5) **Will a Wyoming Health Care Advance Directive be honored in other states?**
   The laws on Advance Directives differ from state to state, so it is unclear whether a Wyoming Advance Directive will be honored in another state. Because an Advance Directive is a clear expression of your wishes about medical care, it will influence that care no matter where you are admitted. However, if you plan to spend a great deal of time in another state, you might want to consider signing an Advance Directive that meets all the legal requirements of that state.

6) **What are "life-sustaining treatments", "terminal conditions", and "permanent unconscious state"?**
   Life-sustaining treatments – These are treatments or procedures that are not expected to cure your terminal condition or make you better. They only prolong dying. Examples are mechanical respirators, which help you breathe, kidney dialysis, which clear your body of wastes and cardiopulmonary resuscitation (CPR), which restores your heartbeat.
   Terminal condition – A terminal condition is defined as an incurable condition for which administration of medical treatment will only prolong the dying process and without administration of these treatments or procedures, death then will occur in a relatively short period of time.
   Permanent unconscious state – A permanent unconscious state means that a patient is in a permanent coma or in any state of unconsciousness, caused by illness, injury or disease. The patient is completely unaware of himself, his surroundings and his environment and to a reasonable degree of medical certainty; there can be no recovery.

Additional information about Advance Directives may be obtained by contacting an attorney or by calling:

Memorial Hospital of Sweetwater County
P. O. Box 1359/1200 College Drive
Rock Springs, WY 82901
307-362-3711

Wyoming Advance Health Care Directive Form
Guidance and Glossary

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs.

Unless you state otherwise, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. Unless you limit the authority of your agent, your agent will have the right to:

a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;

b) Select or dismiss health-care providers and institutions;

c) Approve or deny diagnostic tests, surgical procedures, medication and orders not to resuscitate; and

d) Direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

If you use this form, you may choose whether to complete all or any part of it or you may modify any part of it. You also are free to use a different form.

Once you have completed the form:

Give a copy of the signed and completed form to your primary physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named.

Post a copy of the form on the front of your refrigerator or another location where an emergency responder will easily see it.

You should talk to the person you have named as agent to make sure that he or she fully understands your wishes and is willing to take the necessary responsibility.

You have the right to revoke this advance health care directive or replace this form at any time.

Glossary of Advance Health Care Directive Terms

Advance Health Care Directive: A general term describing two kinds of legal documents, an individual's instruction and a power of attorney for health care. These documents allow a person to give instructions about future medical care in case they are unable to participate in medical decisions due to serious illness or incapacity.

Agent is a person designated in a power of attorney for health care to make health-care decisions for the person granting the power.

Artificial nutrition and hydration: Supplying food and water through a conduit, such as a tube or an intravenous line where the recipient is not required to chew or swallow voluntarily, including, but not limited to, nasogastric tubes, gastrostomies, jejunostomies and intravenous infusions. Artificial nutrition and hydration does not include assisted feeding, such as spoon or bottle feeding.

Capacity: An individual's ability to understand the significant benefits, risks and alternatives to proposed health care and to make and communicate a health-care decision.

Health care: Any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition.

Health care decisions: A decision made by an individual or the individual's agent, guardian, or surrogate, regarding the individual's health care, which may include:

a) Selection and discharge of health care providers and institutions;

b) Approval or denial of diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and c) Directions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care.

Health care institution: An institution, facility or agency licensed, certified or otherwise authorized or permitted by law to provide health care in the ordinary course of business.

Hospice: An institution or service that provides palliative care when medical treatment is no longer expected to cure the disease or prolong life.

Individual Instruction: An individual’s wishes concerning a health-care decisionfor the individual.

Glossary of Advance Health Care Directive Terms (Continued)

Notary Public: A person who administers oaths, certifies documents, takes affidavits, and attests to the authenticity of signatures.

Physician: An individual authorized to practice medicine under the Wyoming Medical Practice Act.

Principal: The person who gives authority to an agent to make health-care decisions in the event that he or she becomes incapacitated. Also, the person for whom the advance health care directive has been created.

Power of Attorney for Health Care: The designation of an agent to make health-care decisions for the individual granting the power. This type of advance directive might also be called a health care proxy, or durable power of attorney for health care.

Health care provider: Any person licensed under the Wyoming statutes practicing within the scope of that license as a licensed physician, licensed physician's assistant or licensed advanced practice registered nurse.

Primary physician: A physician designated by an individual or the individual’s agent, guardian or surrogate to have primary responsibility for the individual’s health care or, in the absence of a designation, or if the designated physician is not reasonably available, a physician who undertakes the responsibility.

Wyoming Advance Health Care Directive Form for:

____

(Print your full name) (Date of Birth)

Please place the completed document on the front of your refrigerator or another location where an emergency responder might easily see it.

These materials have been prepared as a public service by AARP Wyoming and are for informational purposes only and should not be construed as legal advice or as official State of Wyoming documents.

Print your full name: ____

Today's date: ______________________________ **Initial that you have completed the page:** ______

PART 1: POWER OF ATTORNEY FOR HEALTH CARE

PLEASE NOTE: *Answering any of the following questions is optional, but the more information you provide on this form, the better your designated agent may act on your behalf. This form is not to be used to designate a financial power of attorney. It is for health care matters only. This form is in compliance with Wyoming State Statute 35-22-401 through 416.*

(1) Designation of agent: I designate the following person as my agent to make health care decisions for me:

____

(name of person you choose as your agent)

____

(address)

____

(city) (state) (zip code)

____

(home phone) (work phone) (cell phone)

If I revoke my agent's authority, or if my agent is not willing, able or reasonably available to make a health-care decision for me, **I designate as my alternate agent:**

____

(name of person you choose as your alternate agent)

____

(address)

____

(city) (state) (zip code)

____

(home phone) (work phone) (cell phone)

(2) Agent's authority: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care, except as I state here:

____

____

____

(Add additional sheets if needed.)

Print your full name: ____

Today's date: ______________________________ **Initial that you have completed the page:** ______

(3) When agent's authority becomes effective: My agent's authority to make health care decisions for me takes effect at the following time (**check and initial only one (1) option**):

Check Initial

☐ ____ If I check the box and initial, my agent's authority to make health care decisions for me becomes effective only when my primary physician or, in his/her absence, my treating primary health care provider determines that I lack the capacity to make my own health care decisions;

OR

☐ ____ If I check the box and initial, my agent's authority to make health care decisions for me becomes effective only when my primary physician (and **not** when any then treating health care provider of mine) determines that I lack the capacity to make my own health care decisions;

OR

☐ ____ If I check the box and initial, my agent's authority to make health care decisions for me becomes effective as necessary immediately upon my execution of this Advance Health Care Directive Form.

(4) Agent's obligation: My agent shall make health care decisions for me in accordance with this power of attorney for health care using any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent that my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

Print your full name:

____

Today's date: ______________________________ **Initial that you have completed the page:** ______

PART 2: INSTRUCTIONS FOR HEALTH CARE

(5) End-of-Life decisions: I direct that those involved in my care provide, withhold or withdraw treatment in accordance with the choice I have checked and initialed below (check and initial only one option):

Check Initial

☐ ____ (a) **Choice to Prolong Life:** I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

OR

☐ ____ (b) **Choice Not to Prolong Life:** I do not want my life to be prolonged if:

(i) I have an incurable and irreversible condition that will result in my death within a relatively short time;

(ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness;

(iii) The likely risks and burdens of treatment would outweigh the expected benefits.

(6) Artificial nutrition and hydration: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (5) unless I have checked and initialed **one** of the boxes below:

Check Initial

☐ ____ I **want** artificial nutrition regardless of my condition.

☐ ____ I **do NOT** want artificial nutrition regardless of my condition.

☐ ____ I **want** artificial hydration regardless of my condition.

☐ ____ I **do NOT** want artificial hydration regardless of my condition.

Print your full name:

____

Today's date: ____________________________ **Initial that you have completed the page:** ______

(7) Relief from pain:

Check Initial

☐ ____ I **want** treatment for the alleviation of pain or discomfort at all times;

OR

☐ ____ I **do NOT** want treatment for the alleviation of pain or discomfort.

(8) Other wishes: (If you do not agree with the choices above, you may write your own or add to the instructions above. Examples may include: blood or blood products; chemotherapy; simple diagnostic tests; invasive diagnostic tests; minor surgery; major surgery; antibiotics; oxygen; wish to die at home if possible; etc.) I direct that:

____

____

____

____

PART 3: DONATION OF ORGANS AND TISSUES UPON DEATH

(9) Upon my death (check and initial applicable boxes):

Check Initial

☐___ (a) I have arranged to give my body to science.

☐___ (b) I have arranged through the Wyoming Donor Registry to give any needed organs and/or tissues (For enrollment information, call 1-888-868-4747 or visit www.donoregistry.org).

☐___ (c) **I <u>do NOT</u>** wish to donate my body, organs and/or tissues.

Print your full name: ____

Today's date: ______________________________ **Initial that you have completed the page:** ______

PART 4: INFORMATION ABOUT MY HEALTH CARE PROVIDER

(10) The following physician is my primary physician:

____
(name of physician)

____
(address)

____
(city) (state) (zip code)

____
(phone)

More information about my health care can be obtained through:

____
(name of health care institution/hospice)

____
(address)

____
(city) (state) (zip code)

____

(phone)

(11) Effect of copy: A copy of this form has the same effect as the original.

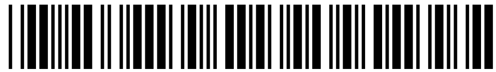
SIGNATURE (Sign and date the form here):

(print your name)

(sign your name) (date)

(address)

(city) (state) (zip code)



SIGNATURES OF WITNESSES or NOTARY PUBLIC:

I declare under penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is known to me to be the principal, and that the principal signed or acknowledged this document in my presence.

Please Note: *Under Wyoming State Statute 35-22-403 (b), a witness may not be a treating health care provider, operator of a treating health care facility or an employee of a treating health care facility.*

First witness

(print witness' name) (address)

(signature of witness) (date)

Second witness

(print witness' name) (address)

(signature of witness) (date)

OR

Notary (in lieu of witnesses)

State of Wyoming

County of________________ } **SS.**

Subscribed and sworn to and acknowledged before me by_______________________,

the Principal, this _________ day of _________________________, ______________.

My commission expires: ____.

____
Notary Public's signature