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RUSH

STATEMENT OF ILLINOIS LAW ON ADVANCE DIRECTIVES

Rush University Medical Center ("RUMC") is committed to protecting and promoting each patient's rights. These include the right to refuse medical or surgical treatment, including life-sustaining care – even if the refusal could speed death – and the right to make advance directives. There are things you should know about these rights.

No one can predict when a serious illness or accident might happen. When it does, you may need someone else to speak or make health care decisions for you. If you plan now, you can plan to get medical treatment in line with what you want.

You have the right to make decisions about the health care you receive now and in the future. An **advance directive** is a written statement you make about how you want your medical decisions to be made if you can't make them for yourself. Federal law requires that you be told of your right to make advance directives when you are admitted to a hospital. However, under Illinois Law, the health care providers may object to your wishes. In that case, you can choose a different health care provider, or you or your representative will be offered one.

Illinois has four types of advance directives: (1) Durable Power of Attorney for Healthcare; (2) Living Will; (3) Declaration for Mental Health Treatment Preference; and (4) Practitioner Orders for Life Sustaining Treatment (POLST). You may choose to discuss with your health care professional, attorney or your physician these advance directives. You may additionally work with your physician to complete POLST or prepare a DNR. You may decide to make more than one.

If you have advance directives already, tell your health care professional and provide them with a copy. You may also want to provide a copy to family members, and you should provide a copy to the person you appoint to make decisions for you in the advance directives.

It is our policy that the care you get at RUMC will not be different based on any choice you make about advance directives, including whether or not you have one.

I. Power of Attorney for Health Care

In Illinois, it is your right to choose someone to be your "health care agent." Your agent is the person you trust to make health care decisions for you if you are unable or do not want to make them for yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of agent in writing. The written form in this document may be used if it meets the legal requirements of Illinois. There are many written and online resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing your advance directive(s).

A **Power of Attorney for Health Care** lets you choose someone to make health care decisions for you in the future, if you are no longer able to make these decisions for yourself. You are called the "principal" in the power of attorney form and the person you choose to make decisions is called your "agent." Your agent would make health care decisions for you if you were no longer able to make these decisions for yourself. So long as you can make these decisions, you will have the power to do so. The agent you choose cannot be your health care provider. You should have someone who is not your agent witness your signing of the power of attorney. In choosing an agent, you should choose:

- A family member or friend who is at least 18 years old
- Someone who knows you well
- Someone who you trust to do what you would want for yourself
- Someone who would be comfortable talking with and questioning your physicians and providers
- Someone who would not be too upset to carry out your wishes if you become too sick
- Someone who can be there for you when you need it and is willing to accept this important role.

In choosing an agent, it is important to talk with your agent and family about things such as:

- What is important to you in your life?
- How important is it for you to avoid pain and suffering?
- If you had to choose, is it more important to live as long as possible, or avoid long-term suffering or disability?
- Would you rather be at home or in a hospital for the last days or weeks of your life?
- Do you have religious, spiritual, or cultural beliefs that you want your agent and others to know?
- Do you wish to contribute to medical science after your death by donating an organ or your whole body?
- Do you have any existing advance directives that discuss your specific wishes about your healthcare?

The types of decisions your health care agent can make are broad. For example, some of the actions your agent could take are:

- Talking with providers about your health conditions
- See your medical records and approve who else may see them.
- Give permission for medical tests, medicines, surgery, and other treatments.
- Choose where you receive care and which providers provide it.
- Decide to accept, withdraw, or decline treatments designed to keep you alive if you are near death or not likely to recover.
- Agree or decline to donate your organs or your whole body if you have not already made this decision.
- Decide what to do with your remains after you have died, if you have not already made plans.
- Talk with other loved ones to help come to a decision.

Unless you include time limits, the health care power of attorney will continue in effect from the time it is signed until your death. You can cancel your power of attorney at any time, either by telling someone or by canceling it in writing. You can name a backup agent to act if the first one cannot or will not act. You cannot name two agents to act together at the same time. If you want to change your power of attorney, you must do so in writing. You may use a standard health care power of attorney form or write your own.

If you do not choose a health care agent, or are unable to make your own health care decisions and have not named an agent in writing, your providers will ask a family member, friend, or guardian to make decisions for you. In Illinois, law directs who will be asked to help. There are some reasons why you may want to choose an agent, rather than relying on the state to choose, for example:

- The people listed by law may not be who you want making decisions for you.
- Some family members or friends might not be able or willing to make decisions as you would want them to.
- Family members and friends may disagree with one another about the issue being decided.
- Under some circumstances, a surrogate may not be able to make the same kinds of decisions that an agent can make.

Once you have completed your Durable Power of Attorney for Health Care Form, you should:

- Sign the form in front of a witness who is at least 18 years old.
- Ask the witness to sign also.
- There is no need for notarization of the form.
- Give a copy to your agent and to each of your backup agents.
- Give another copy to your physician.
- Take a copy when you go to the hospital.

- Keep a copy for yourself in a safe place.
- Show it to your family and friends, along with others who care for you.

II. Living Will Declaration

A **Living Will** tells your health care professional whether you want death-delaying procedures used if you have a *terminal condition* and are unable to state your wishes. A living will, unlike a health care power of attorney, only applies if you have a terminal condition. A *terminal condition* is an incurable and irreversible condition in which death will happen soon and any death delaying procedures serve only to prolong the dying process.

Even if you sign a living will, food and water cannot be withdrawn if it would be the only cause of death. Also, if you are pregnant and your health care professional thinks you could have a live birth, your living will cannot go into effect.

You can use a standard living will form or write your own. You may write specific directions about the death-delaying procedures you do or do not want. Two people must witness your signing of the living will. Your health care professional cannot be a witness. It is your responsibility to tell your health care professional if you have a living will, if you are able to do so. You can cancel your living will at any time, either by telling someone or by canceling it in writing.

If you have both a health care power of attorney and a living will, the agent you name in your power of attorney will make your health care decisions unless he or she is unavailable.

III. Declaration for Mental Health Treatment Preference

A **Declaration for Mental Health Treatment Preference** lets you say if you want to receive electroconvulsive treatment (ECT) or psychiatric medicine when you have a mental illness and are unable to make these decisions for yourself. It also allows you to say whether you wish to be admitted to a mental health hospital for up to 17 days of treatment.

You can write your wishes or choose someone to make your mental health decisions for you. In the declaration, you are called the "principal," and the person you choose is called an "attorney-in-fact." Neither your health care professional nor any employee of a health care facility you are admitted to may be your attorney-in-fact. Different from the Health Care Power of Attorney, your attorney-in-fact must accept the appointment in writing before he or she can start making decisions regarding your mental health treatment. The attorney-in-fact must make decisions in line with what you wrote down in your declaration unless a court orders differently or an emergency threatens your life or health.

Your mental health treatment preference declaration expires three years from the date you sign it. Two people must witness you signing the declaration. The following people may not witness your signing of the declaration: your health care professional; an employee of a health care facility you are admitted to; or a family member related by blood, marriage or adoption. You may cancel your declaration in writing before it expires if you are not receiving mental health treatment at the time of cancellation. If you are receiving mental health treatment, your declaration will not expire, and you may not cancel it until the treatment is successfully completed and physicians agree that you are able to make decisions for yourself.

IV. Practitioner Orders for Life Sustaining Treatment (POLST)

You may ask your provider about having a Practitioner Orders for Life Sustaining Treatment (POLST). A POLST is an advance directive that says that cardiopulmonary resuscitation (CPR) cannot be used if your heart or breathing stops. It can also be used to record your desires for life-sustaining treatment. The POLST travels with you from home to anywhere you go, and must be followed by all health care providers. The Department of Public Health has published a POLST that is available for download at this webpage: **http://www.dph.illinois.gov/sites/default/files/forms/polst-051717.pdf.** This webpage also provides a link to guidance for individuals, health care professionals and health care providers concerning POLST.

The POLST may be completed by a physician, second-year resident, or above, Advance Practice Nurse, or Physician Assistant. The POLST requires your signature or that of your authorized legal representative (your legal guardian, health care power of attorney, or health care surrogate), as well as the signature of your attending practitioner and an adult witness who is 18 years of age or older. A POLST will not be entered into your medical record unless it contains all the required signatures. You can ask your provider to work with you to prepare the POLST.

V. What happens if I don't have Advance Directives?

If you cannot make health care decisions for yourself and do not have an advance directive, a health care "surrogate" may be chosen for you. Under Illinois law, two doctors must certify that you cannot make health care decisions for yourself before a health care surrogate can be appointed. A health care surrogate can be one of the following persons (in order of priority): your legal guardian, spouse, any adult child, either parent, any adult brother or sister, any adult grandchild, a close friend, or legal guardian of the estate.

While your health care surrogate can make most health care decisions for you, there are certain decisions that a surrogate cannot make. For example, a health care surrogate cannot tell your health care professional to withdraw or withhold life-sustaining treatment unless you have a "qualifying condition." A qualifying condition can be (1) a "terminal condition" (an incurable or irreversible injury for which there is no reasonable possibility you will recover, death will happen soon, and treatment will not help); (2) "permanent unconsciousness" (a condition that physicians are very sure will last permanently, without getting better; you aren't showing that you can think, interact with people, or be aware of what is going on around you; and providing life-sustaining treatment will only have a very small medical benefit), or (3) an "incurable or irreversible condition" (an illness or injury for which there is no reasonable possibility you will recover, that will cause your death, that causes severe pain or suffering on you, and treatment will not help). Two doctors must certify that you have one of these qualifying conditions.

There are also limits to what decisions a health care surrogate can make about mental health treatment. A health care surrogate, other than a court-appointed guardian, cannot consent for you to have certain mental health treatments, including treatment by electroconvulsive therapy (ECT), psychiatric medication, or admission to a mental health facility. The health care surrogate can go to court to allow these mental health services.

To avoid these limits, you may want to consider having advance directives.

VI. Final Notes

You should talk with your family, your health care professional, your attorney, and any agent or attorney-in-fact that you appoint about your decision to make advance directives. If they know what health care you want, they will find it easier to follow your wishes. If you cancel or change an advance directive in the future, remember to tell these same people about the change or cancellation.

No health care facility, health care professional, or insurer can make you have an advance directive in order to provide treatment or insurance. It is entirely your decision. If a health care facility, health care professional or insurer does not want to follow your advance directive, they must tell you or your decision maker. They must continue to provide care until you or your decision maker can transfer you to another health care provider who will follow the orders contained in your advance directive.

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

RUSH UNIVERSITY MEDICAL CENTER

POWER OF ATTORNEY FOR HEALTH CARE

Adv Directive-P
Durable Power of Attorney

IDN13150042

MY POWER OF ATTORNEY FOR HEALTH CARE

THIS POWER OF ATTORNEY REVOKES ALL PREVIOUS POWERS OF ATTORNEY FOR HEALTH CARE.

My name (Print your full name): _____

My address: _____

I WANT THE FOLLOWING PERSON TO BE MY HEALTH CARE AGENT

(an agent is your personal representative under state and federal law):

(Agent name) _____

(Agent address) _____

(Agent phone number) _____

MY AGENT CAN MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING:

(i) Deciding to accept, withdraw, or decline treatment for any physical or mental condition of mine, including life-and-death decisions.

(ii) Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.

(iii) Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.

(iv) Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue, or whole body donation, autopsy, cremation, and burial.

The above grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures.

I AUTHORIZE MY AGENT TO: (Please check only one box; if more than one box or no boxes are checked, the directive in the first box below shall be implemented.)

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.
(If no box is checked, the above will be implemented)

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. Starting now, for the purpose of assisting me with my health care plans and decisions, my agent shall have complete access to my medical and mental health records, the authority to share them with others as needed, and the complete ability to communicate with my personal physician(s) and other health care providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself.

☐ Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

LIFE-SUSTAINING TREATMENTS

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes. Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements. SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES **(optional)**:

☐ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.

☐ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY:
The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically in this form.

_____

_____

_____

YOU MUST SIGN THIS FORM, AND A WITNESS MUST ALSO SIGN IT BEFORE IT IS VALID.

My signature: _____ Today's date: _____

HAVE YOUR WITNESS COMPLETE THE FOLLOWING AND SIGN:
I am at least 18 years old, and (check one of the options below):

- ☐ I saw the principal sign this document, or
- ☐ The principal told me that the signature or mark on the principal signature line is his or hers.

I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent, or the successor agent(s) by blood, marriage, or adoption. I am not the principal's physician, mental health service provider, or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the health care facility where the principal is a patient or resident.

Witness printed name: _____

Witness address: _____

Witness signature:_____ Today's date: _____

SUCCESSOR HEALTH CARE AGENT(S) (optional):
If the agent I have selected is unwilling or unable, including if the health care agent is unavailable, nondecisional, or deceased, then I request the person(s) I name below to be my successor health care agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names):

_____
(Successor agent #1 name, address and phone number)

_____
(Successor agent #2 name, address and phone number)

RUSH UNIVERSITY MEDICAL CENTER

LIVING WILL DECLARATION

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

Advance Directive-P
Living Will Declaration

IDN13150001

This declaration is made this _____ day of _____ , 20 _____ (month, year). I, _____ , being of sound mind, willfully and voluntarily make known my desires that my moment of death shall not be artificially postponed.

If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me, and has determined that my death is imminent except for death delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such death delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Signed _____

City, County and State of Residence _____

The declarant is personally known to me and I believe him or her to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. At the date of this instrument I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.

Witness _____

Witness _____

RUSH UNIVERSITY MEDICAL CENTER

DECLARATION FOR MENTAL HEALTH TREATMENT PREFERENCE

Advance Directives

IDN600022

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Place Patient Label

I, _____, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by two physicians or the court that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means electroconvulsive therapy, psychotropic medication, and admission to and retention in a health care facility for up to 17 days for treatment of a mental illness.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

PSYCHOTROPIC MEDICATIONS

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows (check the option that applies):

_____ I consent to the administration of psychotropic medications.

_____ I consent to the administration of psychotropic medications except the following:

_____ I consent to the administration of only the following psychotropic medications:

_____ I do not consent to the administration of any psychotropic medications.

Conditions or limitations:

ELECTROCONVULSIVE TREATMENT

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows (check the option that applies):

_____ I consent to the administration of electroconvulsive treatment.

_____ I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations:

ADMISSION TO AND RETENTION IN FACILITY

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding admission to and retention in a health care facility for mental health treatment are as follows (check the option that applies):

_____ I consent to being admitted to a health care facility for mental health treatment. (This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.)

_____ I do not consent to being admitted to a health care facility for mental health treatment.

Conditions or limitations:

APPOINTMENT OF ATTORNEY-IN-FACT

I appoint the person named below to act as my attorney-in-fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment. My attorney-in-fact is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my attorney-in-fact. If my wishes are not expressed and are not otherwise known by my attorney-in-fact, my attorney-in-fact is to act in what he or she believes to be my best interest.

Name _____

Address _____

_____

Telephone _____

If this person refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my attorney-in-fact, I authorize the following person to act as my attorney-in-fact:

Name _____

Address _____

_____

Telephone _____

ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as attorney-in-fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental health treatment only while the principal is incapable as determined by a court or two physicians. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner when the principal is not incapable.

_____ _____

(Signature of Attorney-in-fact / Date) (Printed Name)

_____ _____

(Signature of Alternate Attorney-in-fact / Date) (Printed Name)

SELECTION OF PHYSICIAN

If it becomes necessary to determine if I have become incapable of giving or withholding informed consent for mental health treatment, I choose the doctor named below to be one of the two physicians who will determine whether I am incapable. If that physician is unavailable, that physician's designee shall determine whether I am incapable.

Name _____

Address _____

_____

Telephone _____

ADDITIONAL INSTRUCTIONS OR CONDITIONS

As I have chosen my preferences for mental health treatment above, I hereby acknowledge that I have read and understand fully all the conditions stated in this form, which will expire in three (3) years after I complete it with my signature and the signatures of two (2) witnesses below:

_____ _____

(Signature of Principal / Date) (Printed Name of Principal)

AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this declaration for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is a person appointed as an attorney-in-fact by this document; the principal's attending physician or mental health service provider or a relative of the physician or provider; the owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident; or a person related to the principal by blood, marriage or adoption.

_____ _____

(Signature of Witness / Date) (Printed Name of Witness)

_____ _____

(Signature of Witness / Date) (Printed Name of Witness)

REVOCATION

I understand that I have the right to revoke this document in whole or in part at any time that I have been determined by a physician to be capable of giving or withholding informed consent for mental health treatment. A revocation is effective when it is communicated to my attending physician in writing and is signed by both a physician and me.

I ,_____ , willfully and voluntarily revoke my declaration for mental health treatment as indicated:

_____ I revoke my entire declaration.

_____ I revoke the following portion of my declaration:

_____

(Signature of Principal / Date)

I, the undersigned physician, have evaluated the principal and determined that he or she is capable of giving or withholding informed consent for mental health treatment.

_____ _____

(Signature of Physician / Date) (Printed Name)

State of Illinois
Illinois Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)	Gender ❑ M ❑ F	
Address (street/city/state/ZIPcode)		

A — CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

Check One

❑ **Attempt Resuscitation/CPR** ❑ **Do Not Attempt Resuscitation/DNR**

(*Selecting CPR means* **Full Treatment** *in Section B is selected*)

When not in cardiopulmonary arrest, follow orders B and C.

B — MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.

Check One *(optional)*

❑ **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*

❑ **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*

❑ **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Optional Additional Orders _____

C — MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired.

Check One *(optional)*

❑ Long-term medically administered nutrition, including feeding tubes.

❑ Trial period of medically administered nutrition, including feeding tubes.

❑ No medically administered means of nutrition, including feeding tubes.

Additional Instructions (e.g., length of trial period)

_____

_____

D — DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

❑ Patient ❑ Agent under health care power of attorney

❑ Parent of minor ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature ***(required)***	Name (print)	Date
_____	_____	_____

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature ***(required)***	Name (print)	Date
_____	_____	_____

E — Signature of Authorized Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Authorized Practitioner Name ***(required)***	Phone ( ) _____ - _____	
_____		
Authorized Practitioner Signature ***(required)***	Date ***(required)***	Page 1
_____	_____	

Form Revision Date - May 2017 **(Prior form versions are also valid.)**

****THIS SIDE FOR INFORMATIONAL PURPOSES ONLY****

Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information

I also have the following advance directives (OPTIONAL)

❑ Health Care Power of Attorney ❑ Living Will Declaration ❑ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number

Health Care Professional Information

Preparer Name	Phone Number
Preparer Title	**Date Prepared**

Completing the IDPH POLST Form

- **The completion of a POLST form is always voluntary, cannot be mandated and may be changed at any time.**
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g. ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at
http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT