Advance Care Planning

Working Together to Honor Your Wishes

Bay Area Hospital

NBMC North Bend Medical Center

Waterfall Community Health Center

AdvancedHealth

Bay Clinic, LLP Physicians and Surgeons

Completing Your Advance Directive

Share Your Wishes

At Bay Area Hospital, we strive to provide the best care possible. To meet this goal, it is important for us to know the level of care you desire and have a way to honor your wishes. One way to ensure that we do just that is by completing an Advance Directive. An Advance Directive is a document that helps communicate your health-care wishes when you are not able to express them yourself. We encourage everyone, regardless of their health status or age, to have an Advance Directive. A copy of your Advance Directive should be in our health record because an unexpected injury or illness could happen to anyone at any time.

Advance Care: *Planning Together*

Goals of Advance Care Planning

Advance care planning has two goals. One is to identify the kind of healthcare you want to receive, if you become unable to communicate your choices. The other goal is to name someone you trust to make healthcare decisions for you, in the event that you cannot do so yourself.

This Packet Includes:

- The Conversation Starter Summary Sheet (How to start the conversation with your family about advance care planning.)
- Oregon Advance Directive Form (The actual legal document to complete)

The Advance Directive, a State of Oregon legal document, communicates this information to your loved ones and to your healthcare providers. It is never too early to complete an Advance Directive.

If you have any questions about this material, please ask your care providers.

After completing this packet, please take a copy to your Primary Care Provider and Bay Area Hospital.

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CONVERSATION STARTER KIT SUMMARY SHEET

NAME _____ DATE _____

The Conversation Project is dedicated to helping people talk about their wishes for end-of-life care. We developed the **Conversation Starter Kit** to help you talk with your loved ones about your—or their—wishes for end-of-life care. After you have the conversation, you can use this Conversation Starter Kit Summary Sheet to record your wishes, and share them with your doctor or others as you wish. And you can return to it over several conversations.

When should you have the conversation?

Even if you're in good health, it's still important to make sure your loved ones, and your healthcare team, know your wishes, since anyone's health status can change suddenly. It's particularly important to have the conversation if you or a loved one has a chronic or serious illness. Every conversation will help your loved ones and your care team understand what matters to you.

? **As you think about how you want to live at the end of your life, what's most important to you?**
Now finish this sentence: What matters to me at the end of life is...
(For example, being able to recognize my children; being in the hospital with excellent nursing care; being able to say goodbye to the ones I love.)

Where I Stand Scales

Select the number that best represents your wishes. (You can write on the dotted line below each scale if you'd like to explain or add notes about your answer.)

As a patient, I'd like to know...

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Only the basics about my condition and my treatment — All the details about my condition and my treatment

If I had a terminal illness, I would prefer to...

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Not know how quickly it is progressing — Know my doctor's best estimation for how long I have to live

As doctors treat me, I would like...

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

My doctors to do what they think is best — To have a say in every decision

How long do you want to receive medical care?

◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Indefinitely, no matter how uncomfortable treatments are — Quality of life is more important to me than quantity

What are your concerns about treatment?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

I'm worried that I won't get enough care

I'm worried that I'll get overly aggressive care

How involved do you want your loved ones to be?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

I want my loved ones to do exactly what I've said, even if it makes them a little uncomfortable

I want my loved ones to do what brings them peace, even if it goes against what I've said

What are your preferences about where you want to be?

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

I wouldn't mind spending my last days in a healthcare facility

I want to spend my last days at home

When it comes to sharing information...

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

I don't want my loved ones to know everything about my health

I am comfortable with those close to me knowing everything about my health

? **Who would you want to make decisions on your behalf if you're not able to? (This person is often called a "healthcare proxy." Check with your state about how to grant this person the legal authority to make medical decisions for you.)**

? **Do you have any particular concerns (questions, fears) about your health? About the last phase of your life?**

? **What do you feel are the three most important things that you want your friends, family, and/or doctors to understand about your wishes and preferences for end-of-life care?**

1. _____

2. _____

3. _____

Institute *for* Healthcare Improvement

the conversation project

CREATED BY THE CONVERSATION PROJECT AND THE INSTITUTE FOR HEALTHCARE IMPROVEMENT

Advance Directive Information

Please note: You do not have to fill out this form.

PART A: Important Information About this Advance Directive

This is an important legal document. It can control critical decisions about your healthcare. Before signing, consider these important facts:

Facts about PART B (Appointing a Healthcare Representative)

You have the right to name a person to direct you healthcare when your cannot do so. This person is called your "healthcare representative." You can do this by using PART B of this form. Your representative must accept on PART E of this form.

In this document, you can write any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts About PART C (Giving Healthcare Instruction)

You also have the right to give instructions for healthcare providers to follow if you become unable to direct your care. You can do this by using PART C of this form.

Facts About Completing this Form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this directive, it will not expire. If you have set an expiration date, and you become unable to direct your healthcare before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your healthcare provider of the revocation.

Despite this document, you have the right to decide your own healthcare as long as you are able to do so.

If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes or add words that better express your wishes. Witnesses must sign PART D.

Advance Directive Form

Print your **name**, **birthdate**, and **address** here:

_____ _____

Name *Address Line 1*

_____ _____

Birthdate *Address Line 2*

Unless revoked or suspended, this advance directive will continue for:

Initial one

_____ My entire life _____ Other period (_____ years)

PART B: Appointment of Healthcare Representative

I appoint _____ as my healthcare representative.

My representative's address is _____

and telephone number is _____ .

I appoint _____ my alternate healthcare representative.

My alternate's address is _____

and telephone number is _____ .

I authorize my representative (or alternate) to direct my healthcare when I can't do so.

_____ _____

Signature *Date*

NOTE: You may not appoint you doctor, an employee of your doctor, or an owner, operator, or employee of your healthcare facility, unless that person is related to you by blood, marriage, or adoption, or that person was appointed before your admission into the healthcare facility.

PART B: Appointment of Healthcare Representative *(continued)*

(B-1) Limits

Special Conditions or Instructions: _____

_____

_____

_____

_____

Initial if this applies:

_____ I have executed a Healthcare Instruction or Directive to Physicians.
My representative is to honor it.

(B-2) Life Support

"Life support" refers to any medical means for maintaining life, including procedures, devices, and mediation. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

Initial if this applies:

_____ My representative MAY decide about life support for me.
(If you don't initial this space, then your representative MAY NOT decide about life support.)

(B-3) Tube Feeding

One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

Initial if this applies:

_____ My representative MAY decide about tube feeding for me.
(If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

Sign here to appoint a healthcare representative:

_____ _____
Signature of person making appointment *Date*

PART C: Healthcare Instructions

In filling out these instructions, keep the following in mind:

- The term "as my physician recommends" means that you want your physician to try life support if your physician believes it could be helpful and then discontinue it if it is not helping your health condition or symptoms.
- "Life support" and "tube feeding" are defined in PART B above.
- If you refuse tube feeding, you should understand that malnutrition, dehydration, and death will probably result.
- You will get care for your comfort and cleanliness, no matter what choices you make.
- You may either give specific instruction by filling out items C-1 to C-4 below, or you may use the general instruction provided by item C-5.

Here are my desires about my healthcare if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

(C-1) Close to Death

If I am close to death and life support would only postpone the moment of my death:

Initial one:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

Initial one:

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

_____ I want NO life support.

(C-2) Permanently Unconscious

If I am unconscious and it is very unlikely that I will ever become conscious again:

Initial one:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

Initial one:

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

_____ I want NO life support.

PART C: Healthcare Instructions *(continued)*

(C-3) Advanced Progressive Illness

If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

Initial one:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

Initial one:

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

_____ I want NO life support.

(C-4) Extraordinary Suffering

If life support would not help my medical condition and would make me suffer permanent and severe pain:

Initial one:

_____ I want to receive tube feeding.

_____ I want tube feeding only as my physician recommends.

_____ I DO NOT WANT tube feeding.

Initial one:

_____ I want any other life support that may apply.

_____ I want life support only as my physician recommends.

_____ I want NO life support.

(C-5) General Instruction

Initial if this applies:

_____ I DO NOT WANT my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in items C-1 to C-4 above.

(C-6) Additional Conditions or Instructions

Insert description of what you want done: _____

(C-7) Other Documents

A "healthcare power of attorney" is any document you may have signed to appoint a representative to make healthcare decisions for you.

Initial one:

_____ I have previously signed a healthcare power of attorney. I want it to remain in effect unless I appointed a healthcare representative after signing the healthcare power of attorney.

_____ I have a healthcare power of attorney, and I REVOKE IT.

_____ I DO NOT have a healthcare power of attorney.

Sign here to give instructions:

Signature *Date*

PART D: Declaration of Witnesses

We declare that the person signing this advance directive:

(a) Is personally known to us or has provided proof of identity;
(b) Signed or acknowledged that person's signature on this advance directive in our presence;
(c) Appears to be of sound mind and not under duress, fraud, or undue influence;
(d) Has not appointed either of us as healthcare representative or alternate representative; and
(e) Is not a patient for whom either of us is an attending physician.

Witnessed by:

Signature of Witness/Date *Printed Name of Witness*

Signature of Witness/Date *Printed Name of Witness*

NOTE: One witness must not be a relative (by blood, marriage, or adoption) of the person signing the advance directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate, or be employed at the healthcare facility where the person is a patient or resident.

PART E: Acceptance By Healthcare Representative

I accept this appointment and agree to serve as healthcare representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document allows me to decide about the person's healthcare only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current healthcare provider if known to me.

Healthcare Representative:

Signature of Healthcare Representative/Date *Printed Name of Healthcare Representative*

Signature of Alternate Representative/Date *Printed Name of Alternate Representative*

The Medical Center for Oregon's Coast

Bay Area Hospital

(541) 269-8111
1775 Thompson Road, Coos Bay, Oregon 97420
www.bayareahospital.org

BAH1926 · Rev. 05/18