1. DESIGNATION of HEALTH CARE AGENT

I, (insert your name), ____________________________________ do

hereby designate and appoint:

Name ____

Address ____

Phone (____) __________ Work (____) __________ ext ___
as my attorney-in-fact to make health care decisions for me as authorized in this document.

Insert the name and address of the person you wish to designate as your attorney-in-fact to make health care decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact:

(1) your treating provider of health care;
(2) an employee of your treating provider of health care;
(3) an operator of a health care facility, or;
(4) an employee of an operator of a health care facility.

2. CREATION of DURABLE POWER of ATTORNEY for HEALTH CARE

By this document I intend to create a Durable Power of Attorney for Health Care by appointing the person designated above to make health care decisions for me. This Durable Power of Attorney for Health Care shall not be affected by my subsequent incapacity.

3. GENERAL STATEMENT of AUTHORITY GRANTED

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in- fact named above full power and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat
a physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraphs 4 or 6.

4. SPECIAL PROVISIONS and LIMITATIONS

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health

treatment facility, convulsive treatment, psycho surgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on your attorney-in-fact's authority, you should list them in the space below. If you do not write any limitations, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this Durable Power of Attorney for Health Care, the authority of my attorney-in-fact is subject to the following special provisions and limitations:

____

____

____

5. DURATION
I understand that this Durable Power of Attorney for Health Care will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decisions for myself when this power of attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself.

(IF APPLICABLE)

I wish to have this Durable Power of Attorney for Health Care end on:

___________________ , 20 ___.

.

6. STATEMENT of DESIRES
a) With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space on the following page.

IF THE STATEMENT *REFLECTS YOUR DESIRES,* INITIAL THE BOX NEXT TO THE STATEMENT

☐ **(1)** I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures.

☐ **(2)** If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used. *(Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.)*

☐ **(3)** If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life-sustaining or prolonging treatments not be used. *(Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed.)*

☐ **(4)** Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld.

☐ **(5)** I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.

MY MEMORIAL SERVICE

If there is to be a memorial service for me, I wish for this service to include the following *(list music, songs, readings or other specific requests that you have):*

____

____

____

____

____

____

____

Add other wishes here *(such as your wishes about donating any or all parts of your body when you die):*

____

____

____

____

____

____

____

____

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

6. STATEMENT of DESIRES *(continued)*

b) It is my intention that this instrument serve both as a self-executing document and as a delegation of power to my attorney-in-fact. This document shall be deemed an exercise of all rights that I may have under the United States Constitution, the Constitution of Nevada, and any other relevant state and federal laws, rules, regulations and decisions, to refuse medical treatment.

c) I desire that my wishes be carried out through the authority given to my attorney-in-fact by this document despite any contrary feelings, beliefs or opinions of other members of my family, relatives or friends.

d) I realize that the situations described in this document are subject to various interpretations, and I am confident that the person(s) named as my attorney-in-fact will exercise the judgment that I myself would exercise if competent.

e) If my attorney-in-fact or my alternate attorney(s) in fact is unavailable, I nevertheless request that my instructions and preferences in this document be observed.

Principal ______

7. DESIGNATION of ALTERNATE ATTORNEY-IN-FACT

(You are not required to designate any alternative attorney-in-fact but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1, page 4, in the event that he or she is unable or unwilling to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternative Attorney-in-fact

Name ____

Address ____

Phone (___) __________ Work (____) __________ ext ____

B. Second Alternative Attorney-in-fact

Name ____

Address ____

Phone (___) __________ Work (____) __________ ext ____

8. PRIOR DESIGNATIONS REVOKED

I revoke any prior durable power of attorney for health care. However, this shall not be construed as a revocation of any durable power of attorney I may have made for the management of my business and/or personal affairs.

9. WAIVER of CONFLICT of INTEREST

If my designated attorney-in-fact or if any alternate designated attorney-in-fact is my spouse or is one of my children then in that event I waive any conflict of interest that said spouse or child may have in carrying out the provisions of this Durable Power of Attorney for Health Care, by reason of the fact that said spouse or child may be a recipient of my estate whether by Will, the laws of intestate succession or pursuant to a Trust or other arrangement.

(You must DATE and SIGN this Durable POWER of ATTORNEY for Health Care)

I sign my name to this Durable Power of Attorney for Health Care on:

____________________ , 20 _____,
(date)

at ____
(city and state)

Signature ____

Name ____

Address ____

Phone (___) ____________ Work (____) _____________ ext ____

Social Security Number _____________________________________

(This Durable Power of Attorney for Health Care will not be valid for making health care decisions unless it is either **(1)** *signed by at least two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature, or* **(2)** *acknowledged before a notary public.)*

10. CERTIFICATE of ACKNOWLEDGMENT of NOTARY PUBLIC

STATE OF NEVADA)
) ss.
COUNTY OF _____________)

On this _____ day of _____________________ , 20 _____ , before me,

_______________________________, *(here insert name of Notary Public)*

personally appeared ____ ,

(here insert name of principal) personally known to me *(or proved to me on the basis of satisfactory evidence)* to be the person who executed the above instrument, and acknowledged to me that he or she executed the same for purposes stated therein. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

____
NOTARY PUBLIC

11. STATEMENT of WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness: **(1)** *a person you designate as the attorney-in-fact,* **(2)** *a provider of health care,* **(3)** *an employee of a provider of health care,* **(4)** *the operator of a health care facility, or* **(5)** *an employee of an operator of a health care facility.*

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged this Durable Power of Attorney for Health Care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney-in-fact by this document, and that I am not a provider of health care, an employee of a provider of health care, the operator of a community health care facility, nor an employee of a health care facility.

Signature ____

Print Name ____

Residence Address ____________________________________

Date ______________________ , 20 ______

Signature ____

Print Name ____

Residence Address ____________________________________

Date ______________________ , 20 ______

NOTE: AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION

12. DECLARATION of WITNESS

I declare under penalty of perjury that I am not related to the principal by blood, marriage or adoption, and to the best of my knowledge I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature ____

Print Name ____

Residence Address ______________________________________

Date __________________________ , 20 _____

Signature ____

Print Name ____

Residence Address ______________________________________

Date __________________________ , 20 _____

COPIES: *You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be available so a copy may be given to your providers of health care.*

DECLARATION/LIVING WILL

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct any attending physician, pursuant to NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

NOTE: *if you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:*

Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld pursuant to this declaration.

NOTICE

Make sure your loved ones can find this document. Make copies for all concerned and make sure they understand its importance.

Signed this _____ day of ______________________, 20 ____ .

Signature ____

Address ____

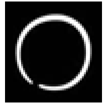
The declarant voluntarily signed this document in my presence.

Witness ____

Address ____

Witness ____

Address ____



A letter to my loved ones. . .

Dear Loved Ones,

I want the best quality of life possible during my last days. Therefore, I hereby request as follows....

☐	(a)	I ask that medical treatment to alleviate pain, to provide comfort, and to mitigate suffering be provided so that I may be as free of pain and suffering possible. Please consult with my doctor in this regard.
☐	(b)	If my temperature is above normal, I want a cool moist cloth put on my head.
☐	(c)	I want my mouth and lips kept moist.
☐	(d)	I need to be kept fresh and clean at all times. I wish to have warm baths often or warm showers, if I am stable enough for a shower.
☐	(e)	I desire to be massaged with or without warm oils as often as you think will help maintain my skin integrity and provide my comfort.
☐	(f)	I want my personal care such as nail clipping, hair combing, teeth brushing, and shaving as long as they do not cause me pain.

I hope my family and friends would consider that. . .

☐	(a)	I enjoy your company and want you with me when possible. I desire that one of you stay with me when it seems that my death may be imminent.
☐	(b)	Please continue to talk to me about daily happenings and events, even if you think I don't understand, because I might be able to understand.
☐	(c)	Please don't be afraid to hold my hand or hug me.
☐	(d)	Please tell the members of my church or synagogue I am sick and ask them to pray and visit me.
☐	(e)	Please maintain a cheerful atmosphere around me.
☐	(f)	Please place pictures of my loved ones in my room, near my bed, or near the place I sit during the day.
☐	(g)	My clothes and bed linens are to be kept clean, and they are to be changed as soon as possible, if they have been soiled.
☐	(h)	If at all possible, allow me to die in my home.
☐	(i)	Please arrange for me to watch on television, or listen to my favorite sports events.
☐	(j)	Let me enjoy the outdoors as often as possible by letting me spend time in my yard, garden and other appropriate outdoor places, even if it causes slight discomfort to either you or me.
☐	(k)	I want to have my favorite types of music played when possible.
☐	(l)	I want to have religious readings read to me when I am near death.
☐	(m)	I want to have my favorite poems read to me from time to time.

I want you to know the following about my thoughts and conerns if I am disabled and cannot convey these thoughts to you verbally. . .

(1)	I want you to know that I love you.	☐
(2)	I would like to be forgiven for the times I have hurt you.	☐
(3)	I forgive you for what you may done to me in my life.	☐
(4)	I want you to know that I do not fear death itself.	☐
(5)	I want all of my family members to recommit their love for one another.	☐
(6)	Please remember me the way I was before I had a terminal illness.	☐
(7)	Please help me maintain meaning to my life during this process of dying by realizing that this is an opportunity for personal growth for all.	☐
(8)	Don’t be afraid to seek counseling, if you have trouble with my death.	☐

If friends want to know how I want to be remembered tell them the following. . .

____

____

____

____

The following person(s) know my funeral plans...

____

____

____

At any memorial service for me, I want to include the following music, songs, redings or other plans for such a service…

____

____

____

I also have the following requests …

____

____

____

____

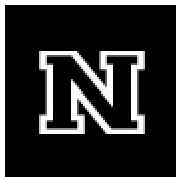
These are requests of my family members, loved ones, and friends, and are not to be considered legal directives to my attorney-in-fact for health care, if any.

(If you wish to change your answer, you may do so by drawing an "X" through the answer you do not want, and circling the answer you prefer.)

Dated this _____ day of ____________, 20 ____

*Signature*_______________________________

*Print Name*_____________________________



For additional information, please contact:
The Nevada Center for Ethics & Health Policy
University of Nevada, Reno/339 – Reno NV. 89557-0133
www.unr.edu/ncehp
www.HealthEthics.org
RENO *Tel. (775) 327-2309 Fax (775) 327-2203*
LAS VEGAS/Southern Nevada *Tel. (702) 257-5594*

Revised 4/07, *MS Word*

NEVADA POLST (Physician Order for Life-Sustaining Treatment)

HIPAA PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS & ELECTRONIC REGISTRY

Faxed, copied or electronic versions of a Nevada POLST are legal and valid

SIDE 1: Medical Orders

Consult this form when patient lacks decisional capacity. It is intended to be honored by any health-care provider who treats the patient in any health-care setting, including, without limitation, a residence, health care facility or the scene of a medical emergency (NRS 449.694.). A section not completed does not invalidate the rest and indicates full treatment for that section.

Last Name/First/Middle Initial		
Date of Birth (dd/mm/yr)	Last 4 SSN	Gender
/ /	__ __ __ __	M F

Section A — CPR — Check one only

CARDIOPULMONARY RESUSCITATION (CPR). *Patient/resident has no pulse & is not breathing.*

☐ Attempt Resuscitation (CPR)
(See Section B: Full Treatment required)

☐ Allow Natural Death (Do Not Attempt Resuscitation)
If available, EMS-DNR #:____________________

When not in cardiopulmonary arrest follow orders in Section B

Section B — Interventions

MEDICAL INTERVENTIONS. *Patient/resident has pulse and/or is breathing.*
Life-sustaining treatment may be ordered for a trial period to determine if there is benefit to the patient. If a life-sustaining treatment is started, but turns out not to be helpful, the treatment can be stopped.

1. ☐ **Comfort Measures Only.** The patient/resident is treated with dignity, respect and kept clean, warm and dry. Reasonable measures are made to offer food and fluids by mouth as tolerated, and attention is paid to hygiene. Medication, positioning, wound care and other measures are used to relieve pain and suffering. Oxygen, suction and manual treatment of airway obstruction may be used as needed for comfort. These measures are to be used where the patient/resident lives. Transfer only if comfort needs cannot be met in current location.
*Other Instructions:*____

2. Limited Medical Interventions. Comfort measures always provided.

a. Life-Sustaining Antibiotics.

☐ No antibiotics. Use other measures to relieve symptoms
☐ Administer antibiotics by mouth as necessary
☐ Administer antibiotics IV as necessary

*Other Instructions:*____

b. Artificially Administered Fluids and Nutrition.

☐ No feeding tube
☐ Defined trial period of feeding tube
☐ Long term feeding tube
☐ No IV fluids
☐ Defined trial period of IV fluids
☐ Long term IV fluids

*Other Instructions:*____

c. Other Limitations of Medical Interventions.

☐ No intensive care admission
☐ No x-ray
☐ No IV (assure agreement with **a.** & **b.** above)
☐ No hyperalimentation
☐ No electrolyte or acid/base corrective measures
☐ No lab work
☐ No antiarrhythmic drugs
☐ No dialysis

*Other Instructions:*____

3. ☐ **Full Treatment.** Includes care above plus endotracheal intubation and cardioversion.
*Additional Instructions:*____

Section C — Physician Signature

Date **(Required)**	Physician Signature **(Required)**	Physician Name (Print)

Physician Office Address	Physician Phone	Physician License No.

Send original with patient when discharged or transferred

NEVADA POLST (Physician Order for Life-Sustaining Treatment)

Patient Name:____ **DOB:**__________

SIDE 2: Supplementary Patient Preferences

Section	
Section D Organ Donation	**ORGAN DONATION** ☐ I have documented on my license or state issued ID that I would like to donate my organs *Other Instructions*:____
Section E Advance Directive	**The following documents/persons have further information regarding patient's/resident's preferences:** **1.** Advance Directive (AD): Living Will, Declaration, Durable Power of Attorney (DPOA) for Health Care ☐ NO ☐ YES **If no AD, skip to #2 below** AD Registered with Secretary of State: ☐ NO ☐ YES - Registration No:__________________ Other location: ____ Appointed Agent #1: ______________________________ Telephone No:__________________ Appointed Agent #2: ______________________________ Telephone No:__________________ **2.** If no agent appointed, another person will make decisions for you as determined by Nevada law. **3.** Court-Appointed Guardian ☐ NO ☐ YES Name:________________________________ Telephone No: ________________________
Section F Signatures	**Patient / Agent / Parent / Guardian** (circle one) **Approval** I have discussed this form, its treatment options and their implications for sustaining life with my / the patient's health care provider. This form reflects my treatment preferences. Signature:____ Date: _____________ **Consent for Sections A and B above were discussed with and given by:** ☐ Patient ☐ Spouse ☐ Adult Child ☐ Court-Appointed Guardian ☐ Parent of Minor ☐ Health Care Agent (DPOA) ☐ Other:__________________ Witnessed by (for any checked above):______________________________ Date:______________ **Preparer's Information** Preparer's Name (print):____ Date:______________ Signature of Person Preparing Form:____
Section G Registry	Physician initial box to right to verify that information has been provided to the patient to submit their completed and signed POLST form to the Living Will Lockbox. Authorization forms can be found at: www.LivingWillLockbox.com. ☐

GENERAL INSTRUCTIONS

- Record all treatments entered on this POLST as orders in patient's chart.
- Copy POLST form for patient record.
- If orders change complete a new POLST and write VOID across this POLST.
- If no new form is completed, full treatment and resuscitation may be provided.
- Transfer or discharge patient with a current POLST form.

WHEN THIS FORM SHOULD BE REVIEWED

This form (POLST) should be reviewed periodically and if:

- The patient/resident is transferred from one care setting or level to another, or
- There is a substantial change in patient/resident health status, or
- The patient/resident treatment preferences change.

THE LASTEST VERSION OF THE POLST FORM IS AVAILABLE FROM THE NEVADA DIVISION OF PUBLIC AND BEHAVIORAL HEALTH.

Send original with patient when transferred or discharged

For Internal Use

EMERGENCY MEDICAL NOTICE:

Advance Directive on file

SEE INSIDE

EMERGENCY MEDICAL NOTICE:
Advance Directive on file

I *(name)* ____
have executed a DURABLE POWER OF ATTORNEY FOR HEALTH CARE pursuant to Nevada Civil Code NRS 449.830-449.860. If I am unable to make my own health care decisions, my designated agent has the legal authority to make those decisions on my behalf, including decisions concerning life-sustaining treatment. In such an event, one of the persons listed on the reverse of this card who has a copy of my Durable Power of Attorney should be contacted immediately in the order listed.

SEE INSIDE

EMERGENCY MEDICAL NOTICE:
Advance Directive on file

Please check with these agents for a copy of my Advance Directive:

1. PRIMARY AGENT NAME ________________________________

Work (____) ______________ Home (____) ______________

Cell (____) ______________ Other (____) ______________

2. 1st ALTERNATE AGENT NAME ____________________________

Work (____) ______________ Home (____) ______________

Cell (____) ______________ Other (____) ______________

2. 2nd ALTERNATE AGENT NAME ____________________________

Work (____) ______________ Home (____) ______________

Cell (____) ______________ Other (____) ______________