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for you when you are unable to make healthcare decisions for yourself.  You are not

required to appoint a person. If you initial the box below, DO NOT complete Sections B,

document expresses my wishes and instructions for medical care when I am unable to   
make medical decisions for myself.

C, D, and E, below.

This Advance Healthcare Directive form, created as a courtesy by Lancaster General   
Health, consists of both a Healthcare Power of Attorney and a Living Will. This

**My Personal Information**

Name:

Street Address:

City, State, Zip Code:

Telephone:  (

)

Date of Birth:

**PART I:  HEALTHCARE POWER OF ATTORNEY**

Part I allows you to appoint a person to make healthcare decisions for you when you   
are unable to make healthcare decisions for yourself.  If you do not appoint a person in   
this Part I, the person(s) identified in 20 Pa.C.S.A. §5461(d) are authorized to make   
healthcare decisions for you.

**A.**

**No Healthcare Agent**

Initial the box below if you choose not to appoint a person to make healthcare decisions

   I choose not to appoint a healthcare agent.

**B.**

**My Healthcare Agent**

I designate the person below to be my healthcare agent:

Name:

Street Address:

City, State, Zip Code:

Telephone:  (

)

Cell Phone:  (

)

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To authorize, withhold, or withdraw medical care and surgical procedures.

My healthcare agent has the authority to make the following healthcare decisions for me

supplied by tube through my nose, stomach, intestines, arteries, or veins.

To authorize my admission to, or discharge from, a medical, nursing, residential,

or similar facility and to make agreements for my care and health insurance for

my care, including hospice and/or palliative care.

To hire and fire medical, social service, and other support personnel responsible

for my care.

To take any legal action necessary to do what I have directed.

To request that a physician responsible for my care issue a do-not-resuscitate

*cross out any healthcare decisions below that you do not want your healthcare agent to*

(DNR) order, including an out-of-hospital DNR order, and sign any required

appoint the following individual as my alternate healthcare agent:

agent, I appoint the following individual as my second alternate healthcare agent:

*make.*)

2.

6.

documents and consents.

**My First Alternate Healthcare Agent**

If the person in Section B is unable or unwilling to serve as my healthcare agent, I

Name:

Street Address:

City, State, Zip Code:

Telephone:  (

)

Cell Phone:  (

)

**My Second Alternate Healthcare Agent**

If my first alternate healthcare agent is unable or unwilling to serve as my healthcare

Name:

Street Address:

City, State, Zip Code:

Telephone:  (

)

Cell Phone:  (

)

**D.**

**Authority of My Healthcare Agent**

in the event I am unable to make these healthcare decisions for myself.  (*You may*

1.

To authorize, withhold, or withdraw nutrition (food) or hydration (water) medically

3.

4.

5.

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**I DO NOT** want aggressive medical care and give the following

**I DO** want aggressive medical treatment and want my healthcare

instructions:

If I have an end-stage medical condition (which will result in my death, despite

If I suffer from severe and irreversible brain damage or brain disease with no

1.

**1.**     I direct that I be given healthcare treatment to relieve pain or provide

or breathing, or be habit forming.

application of aggressive medical care to be burdensome.  I therefore request that my

I direct that all life prolonging procedures be withheld or withdrawn.

healthcare agent respond to any intervening life-threatening conditions in the same

unconscious such as in an irreversible coma or an irreversible vegetative state,

I do not want any of the following life prolonging procedures: CPR;

manner as directed for an end-stage medical condition or state of permanent

and there is no realistic hope of significant recovery, then I choose the following

mechanical ventilation; dialysis; surgery; chemotherapy; radiation

unconsciousness as I have indicated in Part II.  (*Initial your choice below*)

instructions or directions to my healthcare agent:

(*initial your choice below*):

**3.**

treatment; or antibiotics.

generally accepted medical standards.

**Additional Authority of My Healthcare Agent**

realistic hope of significant recovery, I would consider such condition intolerable and the

   I Agree

   I Disagree

2.

Below, I list some things which are important to me and provide additional

**PART II:  LIVING WILL**

The following healthcare treatment instructions exercise my right to make my own   
healthcare decisions. These instructions are intended to provide clear and convincing   
evidence of my wishes to be followed when I lack the capacity to understand, make, or   
communicate my treatment instructions and I am permanently unconscious or in an   
end-stage medical condition.

**A.**

the introduction or continuation of medical treatment) or am permanently

comfort even if such treatment may shorten my life, suppress my appetite

**2.**

team to attempt to prolong my life as long as possible within the limits of

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Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each

Pennsylvania law protects my healthcare agent and healthcare providers from any legal liability for their good faith

I indicate below whether I want to donate my organs and tissues at the time of

 My healthcare agent must follow the instructions in this Part II.

If I designated a healthcare agent in Part I, I indicate below whether my

I indicate below whether I want nutrition (food) or hydration (water) medically

On behalf of myself, my executors, and heirs, I further hold my healthcare agent and my healthcare providers

have an end-stage medical condition or I am permanently unconscious and there

harmless and indemnify them against any claim for their good faith actions in recognizing my healthcare agent’s

witness.  It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your

is no realistic hope of significant recovery (*initial your choice below*):

  I do not want tube feedings to be given.

medical condition or am permanently unconscious (*initial your choice below*):

override any instructions I have given in this Part II.

*choice below*):

  I do not consent to donate my organs or tissues.

authority or in following my treatment instructions.

healthcare powers of attorney and living wills.

healthcare providers).

**Additional Information**

1.

supplied by a tube through my nose, stomach, intestine, arteries, or veins if I

  I do want tube feedings to be given.

2.

healthcare agent must follow the instructions in this Part II if I am in an end-stage

  \_\_\_\_\_ My healthcare agent may use these instructions as guidance and

3.

my death for the purpose of transplant, medical study, or education (*initial your*

  I consent to donate my organs or tissues.

**PART III:  SIGNATURE**

actions in following my wishes as expressed in this document or in complying with my healthcare agent’s direction.

Having carefully read this document, I have signed it this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_, revoking all previous

(*Signature*)

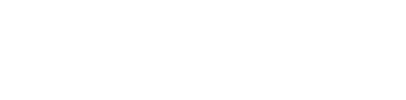
other’s presence.  A person who signs this document on behalf of and at the direction of the principal may not be a

(*Witness Signature*)

(*Witness Printed Name*)

(*Witness Signature*)

(*Witness Printed Name*)

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Discussed with

**E**

No antibiotics. Use other measures to relieve   
symptoms.

**ARTIFICIALLY ADMINISTERED HYDRATION / NUTRITION:**

**D**

**C**

**B**

**A**

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

 Patient

 Parent of Minor

 Health Care Agent

 Court-Appointed Guardian

**Orders for Life-Sustaining**  
 **Treatment (POLST)**

Last Name

person’s medical condition and wishes at the time the orders were issued. Everyone shall be treated with dignity and respect.

One

**is not breathing.**

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

One

**is breathing**.

relieve pain and suffering. Use oxygen, oral suction and manual treatment of airway obstruction as needed for   
comfort.  ***Do not transfer****to hospital for life-sustaining treatment.****Transfer****if comfort needs cannot be met in current*

*location.*

cardiac monitor as indicated. Do not use intubation, advanced airway interventions, or mechanical ventilation.

ventilation, and cardioversion as indicated.

One

One

No hydration and artificial nutrition by tube.

Use antibiotics if life can be prolonged

*Additional Orders*

One

 Other:

**Patient Goals/Medical Condition:**

**Physician /PA/CRNP Printed Name:**

**Physician /PA/CRNP Phone Number**

**Signature (required)**

**Pennsylvania**

First/Middle Initial

Date of Birth

**FIRST**follow these orders, **THEN**contact physician, certified registered nurse practitioner or physician assistant. This is an Order Sheet based on the

**CARDIOPULMONARY RESUSCITATION (CPR): Person has no pulse and**

Check

 CPR/Attempt Resuscitation

 DNR/Do Not Attempt Resuscitation (Allow Natural Death)

**MEDICAL INTERVENTIONS: Person has pulse and/or**

**COMFORT MEASURES ONLY** Use medication by any route, positioning, wound care and other measures to

**LIMITED ADDITIONAL INTERVENTIONS** Includes care described above. Use medical treatment, IV fluids and

Check

***Transfer****to hospital if indicated. Avoid intensive care if possible.*

**FULL TREATMENT** Includes care described above. Use intubation, advanced airway interventions, mechanical

***Transfer****to hospital if indicated. Includes intensive care.*

*Additional Orders*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ANTIBIOTICS:**

Always offer food and liquids by mouth if feasible

Check

Determine use or limitation of antibiotics when   
infection occurs, with comfort as goal

Check

Trial period of artificial hydration and nutrition by tube.

Long-term artificial hydration and nutrition by tube.

*Additional Orders*

**SUMMARY OF GOALS, MEDICAL CONDITION AND SIGNATURES:**

 Health Care Representative

Check

By signing this form, I acknowledge that this request regarding resuscitative measures is consistent with the known   
desires of, and in the best interest of, the individual who is the subject of the form.

**Physician/PA/CRNP Signature (Required):**

**DATE**

**Signature of Patient or Surrogate**

**Name (print)**

**Relationship (write “self” if patient)**

**PaDOH version 10-14-10**

1 of 2

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**Other Contact Information**

Surrogate

Relationship

Phone Number

Health Care Professional Preparing Form

Preparer Title

Phone Number

Date Prepared

**Directions for Healthcare Professionals**

Any individual for whom a Pennsylvania Order for Life-Sustaining Treatment form is completed should ideally have an advance health care   
directive that provides instructions for the individual’s health care and appoints an agent to make medical decisions whenever the patient is

unable to make or communicate a healthcare decision. If the patient wants a DNR Order issued in section “A”, the physician/PA/CRNP   
should discuss the issuance of an Out-of-Hospital DNR order, if the individual is eligible, to assure that an EMS provider can honor his/her

wishes. Contact the Pennsylvania Department of Aging for information about sample forms for advance health care directives. Contact the   
Pennsylvania Department of Health, Bureau of EMS, for information about Out-of Hospital Do-Not-Resuscitate orders, bracelets and

necklaces. POLST forms may be obtained online from the Pennsylvania Department of Health.    [www.health.state.pa.us](http://www.health.state.pa.us/)

**Completing POLST**

Must be completed by a health care professional based on patient preferences and medical indications or decisions   
by the patient or a surrogate.  This document refers to the person for whom the orders are issued as the “individual”

or “patient” and refers to any other person authorized to make healthcare decisions for the patient covered by this   
document as the “surrogate.”

At the time a POLST is completed, any current advance directive, if available, must be reviewed.

Must be signed by a physician/PA/CRNP and patient/surrogate to be valid. Verbal orders are acceptable with follow-   
up signature by physician/PA/CRNP in accordance with facility/community policy. A person designated by the patient

or surrogate may document the patient’s or surrogate’s agreement. Use of original form is strongly encouraged.   
Photocopies and Faxes of signed POLST forms should be respected where necessary

**Using POLST**

If a person’s condition changes and time permits, the patient or surrogate must be contacted to assure that the   
POLST is updated as appropriate.

If any section is not completed, then the healthcare provider should follow other appropriate methods to determine   
treatment.

An automated external defibrillator (AED) should not be used on a person who has chosen “Do Not Attempt   
Resuscitation”

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with “comfort measures   
only,” should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

A person who chooses either “comfort measures only” or “limited additional interventions” may not require transfer or   
referral to a facility with a higher level of care.

An IV medication to enhance comfort may be appropriate for a person who has chosen “Comfort Measures Only.”

Treatment of dehydration is a measure which may prolong life. A person who desires IV fluids should indicate   
“Limited Additional Interventions” or “Full Treatment.

A patient with or without capacity or the surrogate who gave consent to this order or who is otherwise specifically   
authorized to do so, can revoke consent to any part of this order providing for the withholding or withdrawal of life-

sustaining treatment, at any time, and request alternative treatment.

**Review**

This form should be reviewed periodically (consider at least annually) and a new form completed if necessary when:   
 (1) The person is transferred from one care setting or care level to another, or

(2) There is a substantial change in the person’s health status, or   
 (3) The person’s treatment preferences change.

**Revoking POLST**

If the POLST becomes invalid or is replaced by an updated version, draw a line through sections A through E of the   
invalid POLST, write “VOID” in large letters across the form, and sign and date the form.

**PaDOH version 10-14-10**

2 of 2