

NEVADA Advance Directive Planning for Important Healthcare Decisions

Caring Connections
1700 Diagonal Road, Suite 625, Alexandria, VA 22314

800/658-XXXX

Caring Connections, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life, supported by a grant from The Robert Wood Johnson Foundation.

Caring Connections tracks and monitors all state and federal legislation and significant court cases related to end-of-life care to ensure that our advance directives are up to date.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

- Learn about options for end-of-life services and care
- Implement plans to ensure wishes are honored
- Voice decisions to family, friends and healthcare providers
- Engage in personal or community efforts to improve end-of-life care

Please call the HelpLine at 800/658-XXXX to learn more about the LIVE campaign, obtain free resources, or join the effort to improve community, state and national end-of-life care.

If you would like to make a contribution to help support our work, please visit www.nationalhospicefoundation.org/donate. Contributions to national hospice programs can also be made through the Combined Health Charities or the Combined Federal Campaign by choosing #11241.

**Support for this program is provided by a grant from
The Robert Wood Johnson Foundation, Princeton,
New Jersey.**

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Using these materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive healthcare.
2. These materials include:
 - Instructions for preparing your advance directive.
 - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

PREPARING TO COMPLETE YOUR ADVANCE DIRECTIVE

3. Read the HIPAA Privacy Rule Summary on page 4.
4. Read all the instructions, on pages 7 through 11, as they will give you specific information about the requirements in your state.
5. Refer to the Glossary located in Appendix A if any of the terms are unclear.

ACTION STEPS

6. You may want to photocopy these forms before you start so you will have a clean copy if you need to start over.
7. When you begin to fill out the forms, refer to the gray instruction bars - they will guide you through the process.
8. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.
9. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers and/or faith leaders so that the form is available in the event of an emergency.

If you have questions or need guidance in preparing your advance directive or about what you should do with it after you have completed it, please refer to the state-specific contacts for Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives, located in Appendix B.

Summary of the HIPAA Privacy Rule

HIPAA is a federal law that gives you rights over your health information and sets rules and limits on who can look at and receive your health information.

Your Rights

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used and shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Get a report on when and why your health information was shared for certain purposes.
- If you believe your rights are being denied or your health information isn't being protected, you can:
 - File a complaint with your provider or health insurer, or
 - File a complaint with the U.S. Government.

You also have the right to ask your provider or health insurer questions about your rights. You can learn more about your rights, including how to file a complaint from the Web site at www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

Who Must Follow this Law?

- Doctors, nurses, pharmacies, hospitals, clinics, nursing homes, and many other healthcare providers.
- Health insurance companies, HMOs, most employer group health plans.
- Certain government programs that pay for healthcare, such as Medicare and Medicaid.

What Information is Protected?

- Information your doctors, nurses, and other healthcare providers put in your medical record.
- Conversations your doctor has had about your care or treatment with nurses and other healthcare professionals.
- Information about you in your health insurer's computer system.
- Billing information about you from your clinic/healthcare provider.
- Most other health information about you, held by those who must follow this law.

Summary of the HIPAA Privacy Rule (continued)

Providers and health insurers who are required to follow this law must keep your information private by:

- Teaching the people who work for them how your information may and may not be used and shared.
- Taking appropriate and reasonable steps to keep your health information secure.

To make sure that your information is protected in a way that does not interfere with your healthcare, your information can be used and shared:

- For your treatment and care coordination,
- To pay doctors and hospitals for your healthcare,
- With your family, relatives, friends or others you identify who are involved with your healthcare or your healthcare bills, unless you object,
- To protect the public's health, such as reporting when the flu is in your area, or
- To make required reports to the police, such as reporting gunshot wounds.

Your health information cannot be used or shared without your written permission unless this law allows it. For example, without your authorization, your provider generally cannot:

- Give your information to your employer.
- Use or share your information for marketing or advertising purposes, or
- Share private notes about your mental health counseling sessions.

Introduction to Your Nevada Advance Directive

This packet contains two legal documents that protect your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself:

1. The **Nevada Durable Power of Attorney for Healthcare Decisions** lets you name someone to make decisions about your healthcare—including decisions about life support—if you can no longer speak for yourself. The Durable Power of Attorney for Healthcare Decisions is especially useful because it appoints someone to speak for you any time you are unable to make your own healthcare decisions, not only at the end of life.

2. The **Nevada Declaration** is your state's living will. It lets you state your wishes about healthcare in the event that you develop a terminal condition and can no longer make your own healthcare decisions. The term terminal condition means an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of your attending physician, result in death within a relatively short time. The Declaration becomes effective if your doctor determines that your death would occur without the use of life-sustaining treatment.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

Instructions for Completing Your Nevada Durable Power of Attorney for Healthcare Decisions

Attorney-in-fact does not mean a lawyer but is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself.

Whom should I appoint as my attorney-in-fact?

Your attorney-in-fact may be a family member or a close friend whom you trust to make serious decisions. The person you name as your attorney-in-fact should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you. (An attorney-in-fact may also be called an “agent” or “proxy.”)

Unless he or she is your spouse, legal guardian or next of kin, the person you appoint as your attorney-in-fact **cannot** be:

- your healthcare provider,
- an employee of your healthcare provider,
- an operator of a healthcare facility, or
- an employee of a healthcare facility.

You can appoint a second person as your alternate attorney-in-fact. The alternate will step in if the first person you name as attorney-in-fact is unable, unwilling or unavailable to act for you.

How do I make my Nevada Durable Power of Attorney for Healthcare Decisions legal?

The law requires that you have your Durable Power of Attorney for Healthcare Decisions witnessed. You can do this in either of two ways:

1. Have your signature witnessed by a notary public, or
2. Sign your document in the presence of two witnesses, who must also sign the document to show that they personally know you and believe you to be of sound mind and under no duress, fraud, or undue influence, that you signed or acknowledged the Durable Power of Attorney in their presence, and that they do not fall into any of the categories of people who cannot be witnesses. These witnesses cannot be:

- the person you name as your attorney-in-fact,
- a healthcare provider,
- an employee of a healthcare provider,
- an operator of a community care facility, or
- an employee of an operator of a healthcare facility.

Instructions for Completing Your Nevada Durable Power of Attorney for HealthCare Decisions (continued)

Note: At least one of your witnesses must be a person who is not related to you (by blood, marriage or adoption) and who will not inherit from you under any existing will or by operation of law.

Should I add personal instructions to my Nevada Durable Power of Attorney for Healthcare Decisions?

All decisions that your attorney-in-fact makes about withholding or withdrawing life-sustaining treatment must reflect your known desires. The enclosed document lists statements on page 5 about withholding or withdrawing life-sustaining treatment. Read each statement carefully and initial only those statements that reflect your desires. Do not edit or cross out language that does not reflect your desires.

One of the strongest reasons for naming an attorney-in-fact is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add further instructions, you might unintentionally restrict your attorney-in-fact's power to act in your best interest.

By Nevada law, your attorney-in-fact must make decisions concerning the use or non-use of life-sustaining treatment which conform to your desires to the extent your desires are known by your attorney-in-fact. Talk with your attorney-in-fact about your future medical care and describe what you consider to be an acceptable "quality of life." If you want to record your wishes about specific treatments or conditions, you should use your Nevada Declaration (the living will).

What if I change my mind?

You may revoke your Durable Power of Attorney for Healthcare Decisions at any time and in any manner. Your Durable Power of Attorney is automatically revoked if:

- you execute a new Durable Power of Attorney, or
- you appoint your spouse as your attorney-in-fact and your marriage ends.

If you wish to set an expiration date for your Durable Power of Attorney, you may do so on page 4, section 5. If you do not set an expiration date, your Durable Power of Attorney remains valid indefinitely, unless you revoke it.

Instructions for Completing Your Nevada Durable Power of Attorney for Healthcare Decisions (continued)

What other important facts should I know?

Due to restrictions in Nevada law, your attorney-in-fact does not have the power to authorize any of the following:

- Abortion
- Sterilization
- Commitment or placement in a facility for treatment of mental illness
- Convulsive treatment
- Psychosurgery
- Aversive intervention

Instructions for Completing Your Nevada Declaration

How do I make my Nevada Declaration legal?

The law requires that you sign your Declaration in the presence of two adult witnesses of sound mind, who must also sign the document to show that you voluntarily signed the document in their presence.

Note: You do not need to notarize your Nevada Declaration.

Can I add personal instructions to my Declaration?

Yes. You can add personal instructions in the part of the document called "Other directions."

If you have appointed an attorney-in-fact, it is a good idea to write a statement such as, "Any questions about how to interpret or when to apply my Declaration are to be decided by my agent."

What if I change my mind?

You may revoke your Declaration at any time and in any manner, regardless of your mental or physical condition.

Your revocation becomes effective once you or a witness to your revocation notify your doctor or other healthcare provider, who must then make your revocation a part of your medical record.

Due to restrictions in Nevada law, a pregnant patient's Nevada Declaration will not be honored if it is probable that the fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

Under Nevada law, you may either (1) direct your attending physician to withhold or withdraw life-sustaining treatment; *or* (2) designate another individual to make decisions governing the withholding or withdrawal of life-sustaining treatments. If you designate another individual to make these decisions, you should consider appointing the same person that you appointed to be your attorney-in-fact in your Durable Power of Attorney for Healthcare.

**NEVADA DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS –
PAGE 1 OF 8**

WARNING TO PERSON EXECUTING THIS DOCUMENT

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT CREATES A DURABLE POWER OF ATTORNEY FOR HEALTHCARE. BEFORE EXECUTING THIS DOCUMENT, YOU SHOULD KNOW THESE IMPORTANT FACTS:

1. THIS DOCUMENT GIVES THE PERSON YOU DESIGNATE AS YOUR ATTORNEY-IN-FACT THE POWER TO MAKE HEALTHCARE DECISIONS FOR YOU. THIS POWER IS SUBJECT TO ANY LIMITATIONS OR STATEMENT OF YOUR DESIRES THAT YOU INCLUDE IN THIS DOCUMENT. THE POWER TO MAKE HEALTHCARE DECISIONS FOR YOU MAY INCLUDE 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. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF TREATMENT OR PLACEMENTS THAT YOU DO NOT DESIRE.

2. THE PERSON YOU DESIGNATE IN THIS DOCUMENT HAS A DUTY TO ACT CONSISTENT WITH YOUR DESIRES AS STATED IN THIS DOCUMENT OR OTHERWISE MADE KNOWN OR, IF YOUR DESIRES ARE UNKNOWN, TO ACT IN YOUR BEST INTERESTS.

3. EXCEPT AS YOU OTHERWISE SPECIFY IN THIS DOCUMENT, THE POWER OF THE PERSON YOU DESIGNATE TO MAKE HEALTHCARE DECISIONS FOR YOU MAY INCLUDE THE POWER TO CONSENT TO YOUR DOCTOR NOT GIVING TREATMENT OR STOPPING TREATMENT WHICH WOULD KEEP YOU ALIVE.

4. UNLESS YOU SPECIFY A SHORTER PERIOD IN THIS DOCUMENT, THIS POWER WILL EXIST INDEFINITELY FROM THE DATE YOU EXECUTE THIS DOCUMENT AND, IF YOU ARE UNABLE TO MAKE HEALTHCARE DECISIONS FOR YOURSELF, THIS POWER WILL CONTINUE TO EXIST UNTIL THE TIME WHEN YOU BECOME ABLE TO MAKE HEALTHCARE DECISIONS FOR YOURSELF.

5. NOTWITHSTANDING THIS DOCUMENT, YOU HAVE THE RIGHT TO MAKE MEDICAL AND OTHER HEALTHCARE DECISIONS FOR YOURSELF SO LONG AS YOU CAN GIVE INFORMED CONSENT WITH RESPECT TO THE PARTICULAR DECISION. IN ADDITION, NO TREATMENT MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND HEALTHCARE NECESSARY TO KEEP YOU ALIVE MAY NOT BE STOPPED IF YOU OBJECT.

**NEVADA DURABLE POWER OF ATTORNEY FOR HEALTHCARE DECISIONS –
PAGE 2 OF 8**

6. YOU HAVE THE RIGHT TO REVOKE THE APPOINTMENT OF THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTHCARE DECISIONS FOR YOU BY NOTIFYING THAT PERSON OF THE REVOCATION ORALLY OR IN WRITING.

7. YOU HAVE THE RIGHT TO REVOKE THE AUTHORITY GRANTED TO THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTHCARE DECISIONS FOR YOU BY NOTIFYING THE TREATING PHYSICIAN, HOSPITAL, OR OTHER PROVIDER OF HEALTHCARE ORALLY OR IN WRITING.

8. THE PERSON DESIGNATED IN THIS DOCUMENT TO MAKE HEALTHCARE DECISIONS FOR YOU HAS THE RIGHT TO EXAMINE YOUR MEDICAL RECORDS AND TO CONSENT TO THEIR DISCLOSURE UNLESS YOU LIMIT THIS RIGHT IN THIS DOCUMENT.

9. THIS DOCUMENT REVOKES ANY PRIOR DURABLE POWER OF ATTORNEY FOR HEALTHCARE.

10. IF THERE IS ANYTHING IN THIS DOCUMENT THAT YOU DO NOT UNDERSTAND, YOU SHOULD ASK A LAWYER TO EXPLAIN IT TO YOU.

NEVADA DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

NEVADA DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

1. DESIGNATION OF HEALTH CARE AGENT.

I, _____, do hereby designate and appoint:
(name)

NAME: _____

ADDRESS: _____

TELEPHONE NUMBER: _____

as my attorney-in-fact to make health care decisions for me as authorized in this document.

Unless the person is also your spouse, legal guardian or next of kin, none of the following may be designated as your attorney-in-fact: (1) your health care provider, (2) an employee of your healthcare provider, (3) an operator of a health care facility, or (4) an employee 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 by appointing the person designated above to make health care decisions for me. This power of attorney 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 paragraph 4 or 6.

4. SPECIAL PROVISION 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, psychosurgery, 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 his or her 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.)

INSTRUCTIONS

PRINT YOUR NAME

PRINT THE NAME, ADDRESS AND PHONE NUMBER OF YOUR ATTORNEY-IN-FACT

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**NEVADA DURABLE POWER OF ATTORNEY FOR HEALTH CARE
DECISIONS - PAGE 4 OF 8**

ADD PROVISIONS
AND LIMITATIONS
TO YOUR AGENT'S
POWER
(IF ANY)

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 power of attorney 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 power of attorney end on the following date:

6. STATEMENT OF DESIRES.

(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 on the following page.)

PRINT THE
EXPIRATION DATE
(OPTIONAL)

YOU MAY WRITE
YOUR OWN
STATEMENT OF
DESIRES
(IF ANY) ON THE
FOLLOWING PAGE

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**NEVADA DURABLE POWER OF ATTORNEY FOR HEALTH CARE
DECISIONS - PAGE 5 OF 8**

(If the statement reflects your desires, initial the line 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.

Initial _____

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.

Initial _____

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.

Initial _____

4. I direct my attending physician **not** to withhold or withdraw artificial nutrition and hydration by way of the gastro-intestinal tract if such a withholding or withdrawal would result in my death by starvation or dehydration.

Initial _____

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.

Initial _____

(If you wish to change your answer, you may draw an "X" through the answer you do not want and circle the answer you prefer.)

Other or Additional Statements of Desires:

INITIAL THE
STATEMENTS THAT
REFLECT
YOUR WISHES
(OPTIONAL)

ADD FURTHER
PERSONAL
INSTRUCTIONS
(IF ANY)

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**NEVADA DURABLE POWER OF ATTORNEY FOR HEALTH CARE
DECISIONS - PAGE 6 OF 8**

DESIGNATION
OF ALTERNATE
ATTORNEY-IN-FACT
(OPTIONAL)

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 above 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: _____

Telephone Number: _____

B. Second Alternative Attorney-in-fact

Name: _____

Address: _____

Telephone Number: _____

8. PRIOR DESIGNATIONS REVOKED.

I revoke any prior durable power of attorney for health care.

(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

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

_____ at
(date)

_____, _____
(city) (state)

(signature)

(THIS POWER OF ATTORNEY 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.)

FIRST
ALTERNATE

SECOND
ALTERNATE

SIGN AND DATE
YOUR DOCUMENT
AND PRINT YOUR
CITY AND STATE

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**NEVADA DURABLE POWER OF ATTORNEY FOR HEALTH CARE
DECISIONS - PAGE 8 OF 8**

WITNESSES
MUST SIGN AND
DATE YOUR
DOCUMENT AND
PRINT THEIR
NAME AND
ADDRESS

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 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 care facility, nor an employee of an operator of a health care facility.

WITNESS # 1

Signature: _____

Print Name: _____

Date: _____

Residence Address: _____

WITNESS # 2

Signature: _____

Print Name: _____

Date: _____

Residence Address: _____

ONE OF YOUR
WITNESSES
MUST ALSO
AGREE WITH
THIS STATEMENT
AND SIGN
BELOW

(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION)

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: _____

Date: _____

Residence Address: _____

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.

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Courtesy of Caring Connections
1700 Diagonal Road, Suite 625, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

NEVADA DECLARATION – PAGE 1 OF 4

CHOOSE EITHER
DECLARATION
A OR B

INITIAL
DECLARATION A IF
IT REFLECTS YOUR
WISHES

INITIAL AND FILL IN
MISSING
INFORMATION IN
DECLARATION B IF
IT REFLECTS YOUR
WISHES

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A. Declaration Directing My Attending Physician to Withhold or Withdraw Life-Sustaining Treatment.

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 my attending physician to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

Initial _____

OR

B. Declaration Designating Another Person to Decide to Withhold or Withdraw Life-Sustaining Treatment.

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 appoint

[name of person]

or, if he or she is not reasonably available or is unwilling to serve,

[name of alternate person]

to make decisions on my behalf regarding withholding or withdrawal of treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain. (If the person or persons I have so appointed are not reasonably available or are unwilling to serve, I direct my attending physician to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.) *Strike language in the parentheses if you do not desire it.*

Initial _____

If you wish to include the following statement, you must INITIAL the statement in the space provided:

Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this statement 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.

Initial _____

Other directions:

Signed this _____ day of _____, _____.
(date) (month) (year)

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence.

Witness _____

Address _____

Witness _____

Address _____

INITIAL THIS STATEMENT IF IT REFLECTS YOUR WISHES

ADD PERSONAL INSTRUCTIONS (IF ANY)

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

WITNESSING PROCEDURE

WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

ORGAN DONATION
(OPTIONAL)

ORGAN DONATION (OPTIONAL)

Under the Nevada Revised Statute 451.555, an anatomical gift made by a donor and not revoked by the donor before death is irrevocable and does not require consent or concurrence of any person after the donor's death.

An individual may revoke an anatomical gift at any time by (1) a writing signed in the same manner as a document of gift, (2) a statement attached to or imprinted on a donor's motor vehicle operator's license, or (3) any other writing used to identify the individual as refusing to make an anatomical gift. During a terminal illness or injury, the refusal may be an oral statement or other form of communication.

Any person can make an anatomical gift (parental consent is required for those under the age of 18). When a person 18 years of age or older applies for a driver's license or renewal, a question as to whether he or she wishes to donate his or her organs shall be in the application, and the response shall be noted on the license. Revocation suspension, expiration or cancellation of the license does not invalidate the gift.

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your agent or your family will have the authority to make a gift of all or part of your body under Nevada law.

INITIAL THE
STATEMENTS THAT
REFLECT YOUR
WISHES

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/organization: _____

_____ Pursuant Nevada law, I hereby give, effective on my death:

_____ Any needed organ or parts.

_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.

_____ Transplant or therapeutic purposes only.

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NEVADA DECLARATION – PAGE 4 OF 4

In order to comply with the wishes of this individual, organ, tissue, and eye recovery agency representatives are authorized to examine or remove copies of medical records, obtain blood and tissue samples to test for hepatitis, HIV, syphilis, and conduct any other examination to determine the medical suitability of the anatomical gift. A different location may be needed to carry out the recovery of donated tissues. In that case, the body may be transferred to an alternative surgical facility for the recovery of tissues.

SIGN AND DATE

WITNESSES
(PARENT AND ONE
WITNESS NEEDED
IF DONOR IS
BETWEEN THE AGES
OF 13 AND 18;
PARENT AND TWO
WITNESSES FOR
DONORS LESS THAN
AGE TWELVE)

Donor Signature: _____ Date_____

Witness Signature : _____Date_____

Witness Signature: _____ Date_____

Witness Signature (If applicable): _____

Date_____

You Have Filled Out Your Advance Directive, Now What?

1. Your Nevada Durable Power of Attorney for Healthcare Decisions and Nevada Declaration are important legal documents. Keep the original signed documents in a secure but accessible place. Do not put the original documents in a safe deposit box or any other security box that would keep others from having access to them.
2. Give photocopies of the signed originals to your attorney-in-fact and alternate attorney-in-fact, doctor(s), family, close friends, clergy and anyone else who might become involved in your healthcare. If you enter a nursing home or hospital, have photocopies of your documents placed in your medical records.
3. Be sure to talk to your attorney-in-fact and alternate, doctor(s), clergy, and family and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.
4. If you want to make changes to your documents after they have been signed and witnessed, you must complete new documents.
5. Remember, you can always revoke one or both of your Nevada documents.
6. Be aware that your Nevada documents will not be effective in the event of a medical emergency. Ambulance personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate order that states otherwise. These orders, commonly called "non-hospital do-not-resuscitate orders," are designed for people whose poor health gives them little chance of benefiting from CPR. These orders must be signed by your physician and instruct ambulance personnel not to attempt CPR if your heart or breathing should stop.

Currently not all states have laws authorizing non-hospital do-not-resuscitate orders. We suggest you speak to your physician for more information. **Caring Connections does not distribute these forms.**

Appendix A

Glossary

Advance directive - A general term that describes two kinds of legal documents, living wills and medical powers of attorney. These documents allow a person to give instructions about future medical care should he or she be unable to participate in medical decisions due to serious illness or incapacity. Each state regulates the use of advance directives differently.

Artificial nutrition and hydration – Artificial nutrition and hydration supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluids through a tube placed directly into the stomach, the upper intestine or a vein.

Brain death – The irreversible loss of all brain function. Most states legally define death to include brain death.

Capacity - In relation to end-of-life decision-making, a patient has medical decision making capacity if he or she has the ability to understand the medical problem and the risks and benefits of the available treatment options. The patient's ability to understand other unrelated concepts is not relevant. The term is frequently used interchangeably with competency but is not the same. Competency is a legal status imposed by the court.

Cardiopulmonary resuscitation - Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

Do-Not-Resuscitate (DNR) order - A DNR order is a physician's written order instructing healthcare providers not to attempt cardiopulmonary resuscitation (CPR) in case of cardiac or respiratory arrest. A person with a valid DNR order will not be given CPR under these circumstances. Although the DNR order is written at the request of a person or his or her family, it must be signed by a physician to be valid. A non-hospital DNR order is written for individuals who are at home and do not want to receive CPR.

Emergency Medical Services (EMS): A group of governmental and private agencies that provide emergency care, usually to persons outside of healthcare facilities; EMS personnel generally include paramedics, first responders and other ambulance crew.

Healthcare agent: The person named in an advance directive or as permitted under state law to make healthcare decisions on behalf of a person who is no longer able to make medical decisions.

Hospice - Considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice and palliative care involve a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the person's needs and wishes. Support is provided to the persons loved ones as well.

Intubation- Refers to "endotracheal intubation" the insertion of a tube through the mouth or nose into the trachea (windpipe) to create and maintain an open airway to assist breathing.

Life-sustaining treatment - Treatments (medical procedures) that replace or support an essential bodily function (may also be called life support treatments). Life-sustaining treatments include cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and other treatments.

Living will - A type of advance directive in which an individual documents his or her wishes about medical treatment should he or she be at the end of life and unable to communicate. It may also be called a "directive to physicians", "healthcare declaration," or "medical directive."

Mechanical ventilation - Mechanical ventilation is used to support or replace the function of the lungs. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea).

Medical power of attorney - A document that allows an individual to appoint someone else to make decisions about his or her medical care if he or she is unable to communicate. This type of advance directive may also be called a healthcare proxy, durable power of attorney for healthcare or appointment of a healthcare agent. The person appointed may be called a healthcare agent, surrogate, attorney-in-fact or proxy.

Palliative care - A comprehensive approach to treating serious illness that focuses on the physical, psychological, spiritual, and existential needs of the patient. Its goal is to achieve the best quality of life available to the patient by relieving suffering, and controlling pain and symptoms.

Power of attorney – A legal document allowing one person to act in a legal matter on another's behalf regarding to financial or real estate transactions.

Respiratory arrest: The cessation of breathing - an event in which an individual stops breathing. If breathing is not restored, an individual's heart eventually will stop beating, resulting in cardiac arrest.

Surrogate decision-making - Surrogate decision-making laws allow an individual or group of individuals (usually family members) to make decisions about medical treatments for a patient who has lost decision-making capacity and did not prepare an advance directive. A majority of states have passed statutes that permit surrogate decision making for patients without advance directives.

Ventilator – A ventilator, also known as a respirator, is a machine that pushes air into the lungs through a tube placed in the trachea (breathing tube). Ventilators are used when a person cannot breathe on his or her own or cannot breathe effectively enough to provide adequate oxygen to the cells of the body or rid the body of carbon dioxide.

Withholding or withdrawing treatment - Forgoing life-sustaining measures or discontinuing them after they have been used for a certain period of time.

Appendix B

Legal & End-of-Life Care Resources Pertaining to Healthcare Advance Directives

LEGAL SERVICES

The Area Agency on Aging can connect individuals over the age of 60 with low to moderate income to legal referrals in their region.

Anyone over 60 can get legal information and advice on most issues, including:

- Living Wills and Trusts
 - Power of Attorney
 - Social Security
 - Landlord/Tenants concerns and more
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- Must be over 60
 - Free for individuals with low to moderate incomes

To locate legal resources in your region visit the following website:

<http://www.nvelder-care.org/52search/search.php>

OR

Call NevadaCare Connection:

1-866-687-6822

END-OF-LIFE SERVICES

The Nevada Division for Aging Services website provides information on services available to seniors in the state of Nevada. These services include developing, coordinating and delivering a comprehensive support service system in order for Nevada's senior citizens to lead independent, meaningful and dignified lives.

Individuals 60 and older with low to moderate income in the state of Nevada can receive services to including, but not limited to:

- Home health services
 - Legal services
 - Hospice care
 - Adult day care
 - Respite
 - Transportation and many other services
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- Must be 60 and older
 - Free for individuals with low to moderate incomes

To learn more about services offered through The Nevada Division for Aging visit their website: <http://www.nvaging.net/>

OR

Call: 775-829-4700