This document is an Advance Care Plan and includes Appointment of Healthcare Agent as well as declarations of Quality of Life, Treatment, and optional Organ and Tissue Donation. To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.

Once this form is completed:

- Provide a copy to your physician(s).
- Keep a copy in your personal files where it is accessible to others.
- Tell your closest relatives and friends what is in the document.
- Provide a copy to the person(s) you named as your Healthcare Agent.

YOUR ADVANCE CARE PLAN

Adult patients of sound mind have the right to accept or refuse any medical or surgical treatment. This includes the right to accept or refuse treatment through an Advance Care Plan.

WHAT IS AN ADVANCE CARE PLAN?

An Advance Care Plan is a document in which you tell others of your wish to be allowed to die a natural death – if you should become unable to express your wishes in the future. The Advance Care Plan tells medical professionals and members of your family to what extent special means should or should not be used to keep your body alive if you are incurably ill. The Advance Care Plan allows you to refuse certain medical procedures that may only prolong dying or maintain the body in an unconscious state. The Advance Care Plan is to be used only if you become terminally ill or permanently unconscious.

SHOULD YOU HAVE AN ADVANCE CARE PLAN?

It is not necessary that you be seriously ill or anticipating illness in order to benefit from having an Advance Care Plan. In fact, an Advance Care Plan can help protect your family members from unnecessary emotional stress resulting from having to make important decisions in an unexpected crisis. An Advance Care Plan enables you to control the extent to which extraordinary measures will be used to prolong your life, and it relieves others from the responsibility of having to make such decisions.

WHAT TYPES OF TREATMENT ARE AFFECTED?

Your Advance Care Plan affects only those types of treatment which, in the opinion of your doctor, would only serve to postpone the moment of death by artificially altering your body's vital functions.

Some examples include:

• **Cardiopulmonary Resuscitation (CPR):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.

• **Life Support/Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.

• **Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.

• **Tube feeding/IV Fluids:** Use of tubes to deliver food and water to the patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

Your Advance Care Plan may direct that any or all of these not be used.

DOES THIS MEAN GIVING UP OR STOPPING CARE?

An Advance Care Plan affects only measures which are deemed to be useless. Making an Advance Care Plan does not mean that you will be abandoned. Doctors and nurses will continue attending to your needs, and every effort will be made to keep you comfortable. Humane treatment will continue.

WHAT IS A HEALTHCARE AGENT?

You can choose to have another person make healthcare decisions for you in the event you become unable to make decisions. The person you choose is called your "healthcare agent." An agent can be helpful if circumstances arise that are not covered in your Advance Care Plan. An agent can be named on the attached form.

HOW TO MAKE AN ADVANCE CARE PLAN OR APPOINT A HEALTHCARE AGENT

To make an Advance Care Plan, you may fill out the form included with this brochure. Have two other adults witness your signature. If you have decided to name a healthcare agent, fill out the optional Appointment of Healthcare Agent. (If you wish to donate any organs, fill out the Organ Donation form, also included with this brochure.)

WHAT TO DO WITH YOUR ADVANCE CARE PLAN

It is important that your doctor and family members know about your Advance Care Plan.

Once this form is completed:

- Provide a copy to your physician(s).
- Keep a copy in your personal files where it is accessible to others.
- Tell your closest relatives and friends what is in the document.
- Provide a copy to the person(s) you named as your healthcare agent.

IF YOU CHANGE YOUR MIND

Your Advance Care Plan can be revoked at any time by telling your doctor and Healthcare Agent that your wishes have changed.

CAN ONE PERSON MAKE AN ADVANCE CARE PLAN FOR ANOTHER?

If the patient is a child or an adult who can no longer make medical decisions, a close family member or guardian can make an Advance Care Plan for the patient.

HELP IS AVAILABLE

Your Advance Care Plan involves some of life's most important choices and ethical considerations. Such choices are not always easy, but help is available. You may wish to ask your doctor to discuss the questions with you, or refer you to others who are qualified to help. Discussing these considerations with family members may help answer any questions you may have.

It is the policy of Baxter Health to respect patients' rights to refuse unwanted treatment and to comply with any valid Advance Care Plan.

Additional copies of this brochure are available online at www.baxterhealth.org, in the Health Information department, or at Admissions.

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BAXTER HEALTH

624 Hospital Drive
Mountain Home, Arkansas 72653
www.baxterhealth.org

ADVANCE CARE PLAN

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www.baxterhealth.org

ADVANCE CARE PLAN

This document is an Advance Care Plan and includes Appointment of Healthcare Agent as well as declarations of Quality of Life, Treatment and optional Organ and Tissue Donation. **To be legally binding, the Advance Care Plan must be signed and either witnessed or notarized.**

I, _____ , hereby give these advance instructions on how I want to be treated by my doctors and other healthcare providers when I can no longer make those treatment decisions myself.

QUALITY OF LIFE

I want my doctors to help me maintain an acceptable quality of life including adequate pain management. A quality of life that is unacceptable to me means when I have any of the following conditions (you can check as many of these items as you want):

- ☐ **Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
- ☐ **Permanent Confusion:** I become unable to remember, understand or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
- ☐ **Dependent in all Activities of Daily Living:** I am no longer able to talk clearly or move by myself. I depend on others for feeding, bathing, dressing and walking. Rehabilitation or any other restorative treatment will not help.
- ☐ **End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that does not respond anymore to treatment; chronic and/or damaged heart and lungs, where oxygen needed most of the time and activities are limited due to the feeling of suffocation.

TREATMENT

If my quality of life becomes unacceptable to me and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. **Checking "yes" means I WANT the treatment. Checking "no" means I DO NOT want the treatment.**

YES	NO	
☐	☐	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐	☐	**Life Support/Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.
☐	☐	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐	☐	**Tube Feeding/IV Fluids:** Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Other instructions, such as burial arrangements, hospice care, etc.:

_____

_____

_____

_____

_____

(Attach additional pages if necessary)

ORGAN DONATION (optional)

Upon my death, I wish to make the following anatomical gift (please mark one):

- ☐ Any organ/tissue
- ☐ My entire body
- ☐ Only the following organs/tissues:

_____

_____

_____

APPOINTMENT OF HEALTHCARE AGENT

I, _____ , give my agent named below permission to make healthcare decisions for me if I cannot make decisions for myself, including any healthcare decision that I could have made for myself if able. If my agent is unavailable or is unable or unwilling to serve, the alternate named below will take the agent's place.

AGENT

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

_____

HOME PHONE NUMBER

_____

WORK PHONE NUMBER

_____

MOBILE PHONE NUMBER

ALTERNATE AGENT

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

_____

HOME PHONE NUMBER

_____

WORK PHONE NUMBER

_____

MOBILE PHONE NUMBER

_____

PATIENT'S NAME (PLEASE PRINT OR TYPE) DATE

_____

SIGNATURE OF PATIENT (must be at least 18 or emancipated minor)

For Appointment of Healthcare Agent to be legally binding, this form must be signed and either witnessed or notarized in the next section.

SIGNATURE

Your signature should either be witnessed by two competent adults or notarized. If witnessed, neither witness should be the person you appointed as your agent, and at least one of the witnesses should be someone who is not related to you or entitled to any part of your estate.

_____

SIGNATURE OF PATIENT

_____

DATE

WITNESSES (2 required):

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____

SIGNATURE OF WITNESS NUMBER 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____

SIGNATURE OF WITNESS NUMBER 2

This document may be notarized instead of witnessed:

STATE OF ARKANSAS, COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

MY COMMISSION EXPIRES:_____

_____

SIGNATURE OF NOTARY PUBLIC