Your Right to Make Healthcare Decisions

Accepting Medical Treatment
Refusing Medical Treatment
Living Wills
Resuscitation Directives
Substitute Decision Makers
Medical Guardians

Includes these forms:
Medical Power of Attorney
Living Will
CPR Directive

Revised January 2011

For more information or downloadable versions of the forms included in this booklet visit www.ColoradoAdvanceDirectives.com

For help or more information about completing the forms, contact your local physician, hospital, senior group, attorney, or any of the organizations below:

Colorado Advance Directives Consortium
Colorado Bar Association
Colorado Department of Public Health and Environment
Colorado Department of Social Services
Colorado Hospital Association
Colorado Medical Society
Legal Aid Society
The Legal Center for Persons With Disabilities
...or a licensed healthcare facility.

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YOUR RIGHT TO MAKE HEALTH CARE DECISIONS is provided through the Colorado Hospital Association as a public service to the community.

This booklet informs you about your right to make healthcare decisions, including the right to accept or refuse medical treatment.

It provides you with ready-to-use forms on which to record your decisions about medical treatment and your choice of the person you want to make decisions for you when you cannot.

These forms, and any written instructions you make ahead of time about your medical treatment, are called advance directives. This booklet explains the following advance directives and related subjects:

- Substitute Decision Makers: Medical Durable Power of Attorney, Proxy Decision Maker, Guardians
- Living Will
- Cardiopulmonary Resuscitation (CPR Directive)
- Medical Orders for Scope of Treatment

FEDERAL LAW REQUIRES THAT YOU MUST BE GIVEN information on advance directives at the time you are admitted by any hospital, nursing home, HMO, hospice, home health care, or personal care program that receives federal funds (Medicare). You must also be given written information on policies of that facility or provider concerning advance directives.

If your advance directive conflicts with the facility's policy or a particular healthcare professional's moral or religious views, the facility or professional must transfer you to the care of another which will honor your advance directives.

You are not required to have advance directives in order to receive care and treatment, or for admission to a facility. You must only be informed about them. Whether or not you have advance directives, you will receive the medical care and treatment you need.

The advance directive forms in this booklet are specific to Colorado. If you spend a lot of time in another state, you should find out if your Colorado advance directives will be honored there. You may need to complete a separate set of advance directives according to the laws of that other state.

Revised January, 2011
This pamphlet was originally developed by the Advance Directives Coalition. This revision was prepared by the Colorado Advance Directives Consortium in collaboration with the Colorado Hospital Association.

Writing by Jennifer Ballentine, MA, cochair CADC
Design/layout by Bart Windrum, Axiom Action, LLC.
Addendum to Medical Durable Power of Attorney — recommended, not required

1. Signature of the Appointed Agent

Although not required by Colorado law, my signature below indicates that I have been informed of my appointment as a Healthcare Agent under Medical Durable Power of Attorney for (name of Declant).

I am at least eighteen (18) years old. I accept the responsibilities of that appointment, and I have discussed with the Declant his or her wishes and preferences for medical care in the event that he or she cannot speak for him- or herself.

I understand that I am always to act in accordance with his or her wishes, not my own, and that I have full authority to speak with his or her healthcare providers, examine healthcare records, and sign documents in order to carry out those wishes. I also understand that my authority as a Healthcare Agent is only in effect when the Declant is unable to make his or her own decisions and that it automatically expires at his or her death.

If I am an alternate Agent, I understand that my responsibilities and powers will only take effect if the primary Agent is unable or unwilling to serve.

Primary Agent's Signature

Printed Name

Date

Alternate Agent #1 Signature

Printed Name

Date

Alternate Agent #2 Signature

Printed Name

Date

2. Signature of Witnesses and Notary

The signature of two witnesses and a notary are not required by Colorado law for proper execution of a Medical Durable Power of Attorney; however, they may make the document more acceptable in other states.

This document was signed by (name of Declant) in our presence, and we, in the presence of each other, and at the Declant's request, have signed our names below as witnesses. We are at least eighteen (18) years old.

Signature of Witness

Printed Name

Address

Signature of Witness

Printed Name

Address

Notary (optional)

State of __________________________

County of ________________________

SUBSCRIBED and sworn to before me by __________________________, the Declarant, and __________________________, witnesses, as the voluntary act and deed of the Declant this day of __________________________, 20________.

My commission expires: ____________________________

Notary Public

Pursuant to Colorado Revised Statute 15–14.503–509

Pursuant to Colorado Revised Statute 15–14.503–509

*GZPVDPNQMFUFB$13EJSFDUJWF

TFFQBHF

CFTVSFJUJTLFQUJOBWJTJCMF

By providing Your Right to Make Health Care Decisions the Colorado Hospital Association assumes no legal liability for the enforceability or validity of the documents in any individual situation. We regret we are unable to make sure your choices are still valid and that other information, such as contact information, is up to date.

If you complete a COP Directive, you will not be able to make changes to it; however, a COP Directive does not take effect until you are in a hospital; only a COA Directive takes effect when you are in a facility. Keep your COA and COP Directives in a safe, accessible place in your home. Your healthcare providers or an attorney can give you specific guidance.

Federal and Colorado State Law both say that competent adults (those able to make and express decisions) have the right to:

1. Refuse medical treatment at any time for any reason.
2. Consent to or refuse any medical treatment.
3. Refuse medical treatment at any time for any reason.
34. Consent to medical treatment.
42. Consent to medical treatment.
43. Consent to medical treatment.
44. Consent to medical treatment.
47. Consent to medical treatment.
52. Consent to medical treatment.
60. Consent to medical treatment.
63. Consent to medical treatment.
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73. Consent to medical treatment.
74. Consent to medical treatment.
75. Consent to medical treatment.
76. Consent to medical treatment.
77. Consent to medical treatment.
78. Consent to medical treatment.
82. Consent to medical treatment.
84. Consent to medical treatment.
YOUR RIGHT TO INFORMED CONSENT

Except in emergencies, you must give consent to receive medical treatment. Before giving your consent, you must be told what the treatment is for, why and in what way it will be helpful, whether it has any risks or likely side effects, what results are expected or possible, and whether there are any alternatives.

If you have questions, you should ask them and make sure you understand the answers. Then you should think about the information and consider it carefully. If you can and want to, get a second opinion from another healthcare provider. Talk it over with family or friends—and then make your choice and tell your decision to your healthcare provider.

YOUR RIGHT TO ACCEPT MEDICAL TREATMENT

Once you have been fully informed about a proposed treatment, you have the right to accept. Sometimes a verbal “OK” is enough, or you may be asked to sign a consent form. This form can be complicated and detailed. If you are not sure what it all means, ask for an explanation and be sure you understand before you sign.

YOUR RIGHT TO REFUSE MEDICAL TREATMENT

Once you have been fully informed about a proposed treatment, you have the right to refuse. You can refuse any medical treatment at any time for any reason, even if you might get sicker or even die as a result.

YOUR RIGHT TO MAKE YOUR WISHES KNOWN

If you have preferences about what medical treatments you want to accept or refuse, you have the right to make those wishes known. And you have the right to expect that your wishes will be honored, even if you get so sick you can’t communicate or make decisions. In order to make sure your wishes are

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**Medical Durable Power of Attorney for Healthcare Decisions**

I. Appointment of Agent and Alternates

<table>
<thead>
<tr>
<th>Name of Agent</th>
<th>Address</th>
<th>Telephone Number</th>
<th>Email (if available)</th>
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<tbody>
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<td>Agent</td>
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<td>Agent</td>
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II. When Agent’s Powers Begin

Pursuant to Colorado Revised Statute 15–14.503–509

III. Instructions to Agent

My Agent shall make healthcare decisions as I direct below, or, if I have not expressed a choice about the decision or healthcare service, as I make known to him or her in some other way. If I cannot express a choice about the decision or healthcare service, my Agent shall make healthcare decisions as I am unable to make or express my own decisions.

- If I have a living will or other advance directive, my Agent will abide by my instructions in my living will or other advance directive.
- If I have not completed a living will or other advance directive, my Agent shall make decisions on the basis of what I have told my Agent about my wishes and values, and in consultation with my family and friends.
- If I have not expressed a choice about the decision or healthcare service, my Agent shall make healthcare decisions as I have in the past or, if I have not made choices in the past, as I would have made them if I were able to do so.

IV. Appointment of Substitute Agent(s)

By this document, I appoint the following person(s) to act as my substitute agent(s) to make healthcare decisions when I cannot:

<table>
<thead>
<tr>
<th>Name of Substitute Agent</th>
<th>Address</th>
<th>Telephone Number</th>
<th>Email (if available)</th>
</tr>
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<tbody>
<tr>
<td>Substitute Agent</td>
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<td>Substitute Agent</td>
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</tbody>
</table>

V. Effective Date

Date: ____________________________

Signature of Declarant: ____________________________

Prepared for Colorado Board of Medicine 25–14.501 (309)
### Advance Directive for Surgical / Medical Treatment (Living Will) (continued)

#### IV. CONSULTATION WITH OTHER PERSONS

I authorize my healthcare providers to discuss my condition and care with the following persons, understanding that they are not doctors or employees of the attending doctor or healthcare facility:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Telephone number or email address</th>
</tr>
</thead>
<tbody>
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#### VIII. DECLARATION OF WITNESSES

I declare that I am of sound mind and body and have had the opportunity to consult with and discuss my condition and care with the persons listed above.

- In the presence of the above-named witnesses, we have read and heard the above declaration.
- We did not sign the Declarant's signature. We are not doctors or employees of the attending doctor or healthcare facility.
- We are not creditors nor heirs of the Declarant and have no claim against any portion of the Declarant's estate at the time this declaration was signed.
- We are over the age of eighteen (18) years old and under no pressure, undue influence, or otherwise disqualifying disability.

<table>
<thead>
<tr>
<th>Witness 1 Name</th>
<th>Witness 1 Relationship</th>
<th>Witness 1 Signature</th>
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</table>

<table>
<thead>
<tr>
<th>Witness 2 Name</th>
<th>Witness 2 Relationship</th>
<th>Witness 2 Signature</th>
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#### V. NOTIFICATION OF OTHER PERSONS

Before withholding or withdrawing life-sustaining procedures, my healthcare providers shall make a reasonable effort to notify the following persons that I am in a terminal condition or Persistent Vegetative State. My healthcare providers have notified the following persons:

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Telephone number or email address</th>
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<tbody>
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</tbody>
</table>

I do NOT authorize these persons to make medical decisions on my behalf, unless I have appointed one or more of them as my Healthcare Agents under a Medical Durable Power of Attorney.

#### VI. ANATOMICAL GIFTS

I authorize my healthcare providers to make decisions regarding the donation of my organs and/or tissues, if medically possible.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
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</table>

#### VII. SIGNATURE

I execute this declaration, as my free and voluntary act, this day of _________________________, 20____.

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
</tr>
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#### Notary (optional)

[Notary statement and signature]

Pursuant to Colorado Revised Statute 15–18.101–113, this is declared a valid medical declaration.

### MEDICAL DURABLE POWER OF ATTORNEY

You appoint your healthcare agent by completing a Medical Durable Power of Attorney (MDPOA) form. An MDPOA form, along with more information about the MDPOA/healthcare agent, is provided in this booklet. A healthcare agent only has authority to make healthcare decisions. An MDPOA cannot pay your bills, buy or sell real estate or other items of property for you, manage your bank accounts, etc. For that, you need to appoint a Financial or General Durable Power of Attorney. Forms to appoint other powers of attorney are available free from various Web sites or office supply stores, but it is a good idea to consult an attorney first. Low-cost legal advice is available from the Colorado Bar Association, www.cobar.org, or 303.860.1113.
Anyone with a close interest in your care can be included in the group that
Proxy Decision Maker for Healthcare or appointment of a guardian.
If you do not appoint a healthcare agent or MDPOA while you are able to
ideally, this person knows you and your wishes for treatment best. If your
wishes are not known, the Proxy must act in your best interests.
The doctor must make a reasonable effort to tell you who the Proxy is, and
you have a right to object to the person selected to be your Proxy or to any of
the Proxy’s decisions. If you later regain the ability to make and express your
own decisions, the Proxy is relieved of duty.

Anyone with a close interest in your care can be included in the group that
selects the Proxy; no one can be deliberately excluded. However the mem-
bership of the group depends on whom the doctor knows and contact and
whether they are available. This process is somewhat unusual in the health-
care field. If some Colorado healthcare providers do not know about it, they
may just turn to whomever among your family and friends happens to be
there at the time. This might work for the time being, but if there is any kind
of conflict, a decision maker chosen in this way has no real legal standing.

Once the group of interested persons reaches agreement, the doctor then
have a close interest in your well-being, including your spouse or partner,
parents, children, grandparents, siblings, even close friends. Then the as-
sembled group must choose one person to be your Proxy Decision Maker.
Ideally, this person knows you and your wishes for treatment best. If your
wishes are not known, the Proxy must act in your best interests.

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sembled group must choose one person to be your Proxy Decision Maker.
Ideally, this person knows you and your wishes for treatment best. If your
wishes are not known, the Proxy must act in your best interests.
A CPR Directive is a type of advance directive that you make for yourself or your behalf—to refuse resuscitation. CPR is an attempt to revive someone whose heart and/or breathing has stopped by using special drugs and/or machines or by firmly and repeatedly pressing the chest. If you have a CPR Directive and your heart and/or lungs stop or malfunction, your consent to CPR is assumed. However, if you have a CPR Directive refusing resuscitation, and your heart and/or lungs stop or malfunction, then paramedics and doctors, emergency personnel or others will not press on your chest or use breathing tubes, electric shock, or other procedures to get your heart and/or lungs working again.

A CPR Directive is not exactly the same as a DNR (Do Not Resuscitate) order, although many people refer to the CPR Directive as a DNR. A DNR order is an order written in your medical chart by your doctor while you are being cared for in a healthcare facility, such as a hospital or nursing home. The doctor will likely discuss this order with you or your surrogate decision maker, but does not have to. DNR orders are written when your doctor believes that resuscitation would not work or might cause more harm than good. (Fewer than 1 in 10 very elderly, frail, or seriously ill persons will survive a resuscitation attempt; if they do survive, they might end up with traumatic injuries or brain damage.) If you recover well enough to leave the facility, the DNR order expires at your discharge.

A CPR Directive is a type of advance directive that you make for yourself or an authorized decision maker makes for you, and it is valid outside of the healthcare facility. Signing a CPR Directive does not mean you won't receive other medical care such as medicine, other treatment for pain, bleeding, broken bones or comfort care.

(CPR Directive continued)

Anyone over the age of 18 can sign a CPR Directive. According to the CPR Directive law, a physician must also sign the CPR directive, indicating that you have been informed of what will happen if you refuse CPR and that refusal is appropriate due to your age or medical condition. You can revoke a CPR directive at any time by destroying it or by writing a statement that you revoke it on the form. If you sign a CPR directive for yourself, no one else can revoke it. If your agent, Proxy, or guardian signs one for you, they can revoke it.

Even if you have other types of advance directives, a CPR Directive is strongly recommended if you do not want to be resuscitated. Colorado law does not require that a specific CPR Directive form be used and copies, faxes, and scans of the form are also valid. A template prepared and approved by the Colorado Department of Public Health and Environment appears on the reverse side of this fold.

If you do sign a CPR directive, you should keep the form handy and visible so that emergency personnel or anyone else trying to help you in an emergency can see the form and understand your wishes. At home, place the CPR directive in a clearly marked envelope on your refrigerator, by your bedside, or by your front door. If you are out and about, carry one in your purse or wallet. A CPR alert bracelet or necklace can be ordered from Award and Sign Connection, www.AwardAndSign.com, 303-799-8979, or MedicAlert Foundation, www.MedicAlert.org, 888-633-4298.

CPR DIRECTIVES AND MINORS After a physician issues a Do Not Resuscitate order for a minor child—and only then—the parents of the minor, if married and living together, or the custodial parent or the legal guardian may execute a CPR Directive for the child.
with a healthcare provider who can explain what each of the choices means for that patient at that time. Then it is signed by the patient or healthcare agent/Proxy and a physician, advanced practice nurse, or physician’s assistant. When signed, it becomes a medical order set, not an advance directive.

The MOST stays with the patient and is honored in any setting: hospital, clinic, day surgery, long-term care facility, assisted living residence, hospice, or at home. In this way, the MOST closes gaps in communication about treatment choices as patients transfer from setting to setting. The original is brightly colored for easy identification, but photocopies, faxes, and electronic scans are also valid.

The MOST does not replace or revoke advance directives. Choices on the MOST should be consistent with any advance directives the patient previously completed, but the MOST does not cover every treatment or instruction that might be addressed in an MDPOA or Living Will. The choices and directives documented there are still valid. The MOST overrules prior instructions only when there is a direct conflict. A section on the back prompts patients and providers to regularly review, confirm, or update choices based on changing conditions.

A MOST form is not included in this booklet; if you would like more information about the MOST form or program, please consult a healthcare provider or visit www.ColoradoAdvanceDirectives.com.

**Organ and Tissue Donation** Any advance directive may include a written statement of your desire to donate organs or tissues. Please be aware that if you do wish to donate organs, your advance directive may be set aside for a time to allow your organs to be recovered before life-sustaining treatment is withdrawn (see section on the Living Will, page 11). If you refuse CPR, or cardio-pulmonary resuscitation, by executing a CPR directive (see page 13), you may not be able to donate organs, but you can still donate tissues, subject to some limitations of age, health status, and sexual orientation. For more information about organ and tissue donation, consult with your healthcare provider or contact Donor Alliance, www.DonorAlliance.org, or (303) 329-4747. If you do wish to donate organs or tissues, be sure your family knows your decision, as they will be asked to give consent to the donation procedure—and they have the final say.

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### Patient’s Information

- **Name:**
- **Date of Birth:**
- **Address:**
- **Telephone:**
- **Physician’s Name:**
- **Physician’s License #:**

### Physician’s Information

- **Name:**
- **Address:**
- **Telephone:**

### Directive Attestation

- **Patient (Patent’s Name):**
  - **Date of Birth:**
  - **Gender:**
  - **Race/Ethnicity:**
    - Other
    - **Hair Color:**
    - **Eye Color:**
    - **Other:**
    - **Sexual Orientation:**

- **Name of Agent/Legally Authorized Guardian/Parent of Minor Child:**
  - **Date of Birth:**
  - **Gender:**
  - **Race/Ethnicity:**

### Patient’s or Authorized Agent’s Directive to Withhold Cardiac-Pulmonary Resuscitation (CPR)

- **Cardio-Pulmonary Resuscitation (CPR):**
  - Check mark the information that applies:
  - **Patient:**
    - I am over the age of 18 years, of sound mind and acting voluntarily. It is my desire to initiate this directive on my own behalf. I have been advised that as a result of this directive, if my heart or breathing stops or malfunctions, I will not receive CPR and I may die.
  - **Authorized Agent/Legally Authorized Guardian/Parent of Minor Child:**
    - I am legally authorized to act on behalf of the patient named above in the issuance of this directive. I have been advised that as a result of this directive, if the patient’s heart or breathing stops or malfunctions, the patient will not receive CPR and may die.

### Tissue Donation

- **I hereby make an anatomical gift, to be effective upon my death of:**
  - Skin
  - Bone, related tissues and tendons
  - Cartilage
  - Ear
  - Cornea
  - Bone, related tissues and tendons

- **If applicable—Name of hospice program/provider:**

- **Physician’s Name:**
  - **Date:**

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**Procedures for Tissue Donation**

- **Autopsy:** Tissue donation does not interfere with an autopsy.
- **Bone Marrow Transplant:** Tissue donation is not interfered with by bone marrow transplantation.

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**Hospice Care**

- **Directing Hospice:** It is important to tell your healthcare provider, hospice or home health agency about your intentions, to ensure that your desires are accurately communicated to your physician or health care provider.

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**Special Instructions**

- **Transport to a transplant center:**
  - To ensure that the tissue is preserved for transplant, it must be transported to the transplant center within 24 hours of death. The local tissue program can assist you with getting the tissue to the transplant center.

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**Signatures**

- **Patient’s Signature:**
- **Date:**
- **Authorizing Agent’s Signature:**
- **Date:**
Medical Durable Power of Attorney

MEDICAL DURABLE POWER OF ATTORNEY (MDPOA) is a document you sign naming someone to make your healthcare decisions if and when you are not able to. The person you name is called your healthcare agent. Your MDPOA can become effective immediately, or you can make it become effective only when you are unable to make your own medical decisions.

You can appoint anyone to be your healthcare agent as long as that person is at least 18 years old, mentally competent, and willing to be your agent. Your agent should also be someone who can confidently deal with lots of healthcare providers over what could be a long time. It is preferable to pick an agent who lives in the same state or even city as you do, and it’s also a good idea to pick one or two back-up agents, in case your first choice is not available or able to serve. Appointing two or more people as co-agents is not recommended.

Your healthcare agent has all the powers of decision making you do: He or she can consult with healthcare providers, review or get copies of your medical records, and make all necessary healthcare treatment and placement decisions. The agent must act according to his or her understanding of what your wishes and preferences would be. He or she must set aside his or her own values and preferences and do what you would do.

Therefore, it is very important to be sure your agent understands what your wishes are, what you consider to be acceptable, and when you would say no. Talk to your agent about your values, any religious or moral commitments you have, and your goals for treatment. What burdens of treatment (side effects, pain, nausea, fatigue, limitations on activity or thinking, etc.) are
(Medical Durable Power of Attorney continued)

acceptable to you and which are not? What benefits do you hope the treatment will provide?

Do not assume that the person you pick to be your agent knows all of this, just because he or she knows you well. Studies have shown that even spouses who have been married for decades are often wrong when asked to guess what their partners would prefer! In fact, your spouse or life partner may not be the best choice of agent, just because of his or her close involvement in the outcome of your treatment. If you appoint your spouse as your agent, and then later you are divorced, legally separated, or your marriage is annulled, your former spouse is automatically removed as your agent unless expressly stated otherwise in your MDPOA.

You may put instructions into your MDPOA document to help guide your agent and your healthcare providers. A MDPOA form appears at the back of this booklet.

Your MDPOA does not need to be witnessed or notarized. However, most other states require witnesses, so if you plan to use your MDPOA in another state, it’s a good idea to have it witnessed. You can cancel, or revoke, your MDPOA at any time, assuming you have the mental capacity to do so, and your agent can resign at any time. If you have not appointed a back-up agent and can’t make decisions for yourself, then a Proxy Decision Maker must be selected or a guardian appointed by the court.

Living Will

A LIVING WILL is a document you sign telling your doctors to stop or not start life-sustaining treatments if you are in a terminal condition and can’t make your own decisions or if you are in a persistent vegetative state (PVS). A terminal condition is one that is incurable or irreversible and for which life-sustaining treatment will only postpone the moment of death. Persistent vegetative state results from a severe brain injury and generally means that the person is alive and may appear to sleep and wake, but is completely unaware of his or her surroundings; cannot speak, drink, or eat; and may not be able to feel or react to pain.

A Living Will only goes into effect 48 hours after two doctors certify that you are in a terminal condition and can’t make your own decisions or you are in PVS. Your doctors must make a good effort to notify persons close to you that this certification has been made and that they will withdraw or withhold life-sustaining treatment within two days. You can include a list of persons to be notified in the Living Will document, with their contact information. You can also include a list of persons authorized to talk to your doctors about your condition and care. These persons are not authorized to make any decisions about your care, however.

In Colorado, you may also designate in your Living Will that your doctors should stop or not start any tube feeding and other forms of artificial nutrition and hydration, once the terminal or PVS certification has been made, unless they consider it is necessary to provide comfort or relieve pain. You may also include other instructions about your care, but these instructions will only go into effect at the same time as the Living Will: when your doctors certify you are in a terminal condition and can’t make your own decisions or you are in PVS. The Living Will is not the place to record general
acceptable to you and which are not? What benefits do you hope the treatment will provide?

Do not assume that the person you pick to be your agent knows all of this, just because he or she knows you well. Studies have shown that even spouses who have been married for decades are often wrong when asked to guess what their partners would prefer! In fact, your spouse or life partner may not be the best choice of agent, just because of his or her close involvement in the outcome of your treatment. If you appoint your spouse as your agent, and then later you are divorced, legally separated, or your marriage is annulled, your former spouse is automatically removed as your agent unless expressly stated otherwise in your MDPOA.

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MDPOA is a document you sign naming someone to make your healthcare decisions if and when you are not able to. The person you name is called your healthcare agent. Your MDPOA can become effective immediately, or you can make it become effective only when you are unable to make your own medical decisions.

You can appoint anyone to be your healthcare agent as long as that person is at least 18 years old, mentally competent, and willing to be your agent. Your agent should also be someone who can confidently deal with lots of healthcare providers over what could be a long time. It is preferable to pick an agent who lives in the same state or even city as you do, and it's also a good idea to pick one or two back-up agents, in case your first choice is not available or able to serve. Appointing two or more people as co-agents is not recommended.

Your healthcare agent has all the powers of decision making you do: He or she can consult with healthcare providers, review or get copies of your medical records, and make all necessary healthcare treatment and placement decisions. The agent must act according to his or her understanding of what your wishes and preferences would be. He or she must set aside his or her own values and preferences and do what you would do.

Therefore, it is very important to be sure your agent understands what your wishes are, what you consider to be acceptable, and when you would say no. Talk to your agent about your values, any religious or moral commitments you have, and your goals for treatment. What burdens of treatment (side effects, pain, nausea, fatigue, limitations on activity or thinking, etc.) are
A CPR Directive is a type of advance directive that you make for yourself or whose heart and/or breathing has stopped by using special drugs and/or machines or by firmly and repeatedly pressing the chest. If you have a CPR Directive and your heart and/or lungs stop or malfunction, your consent to CPR is assumed. However, if you have a CPR Directive refusing resuscitation, and your heart and/or lungs stop or malfunction, then paramedics and doctors, emergency personnel or others will not press on your chest or use breathing tubes, electric shock, or other procedures to get your heart and/or lungs working again.

A CPR Directive is not exactly the same as a DNR (Do Not Resuscitate) order, although many people refer to the CPR Directive as a DNR. A DNR order is an order written in your medical chart by your doctor while you are being cared for in a healthcare facility, such as a hospital or nursing home. The doctor will likely discuss this order with you or your surrogate decision maker, but does not have to. DNR orders are written when your doctor believes that resuscitation would not work or might cause more harm than good. (Fewer than 1 in 10 very elderly, frail, or seriously ill persons will survive a resuscitation attempt; if they do survive, they might end up with traumatic injuries or brain damage.) If you recover well enough to leave the facility, the DNR order expires at your discharge.

A CPR Directive is a type of advance directive that you make for yourself or an authorized decision maker makes for you, and it is valid outside of the healthcare facility. Signing a CPR Directive does not mean you won’t receive other medical care such as medicine, other treatment for pain, bleeding, broken bones or comfort care.

Anyone over the age of 18 can sign a CPR Directive. According to the CPR Directive law, a physician must also sign the CPR directive, indicating that you have been informed of what will happen if you refuse CPR and that refusal is appropriate due to your age or medical condition. You can revoke a CPR directive at any time by destroying it or by writing a statement that you revoke it on the form. If you sign a CPR directive for yourself, no one else can revoke it. If your agent, Proxy, or guardian signs one for you, they can revoke it.

Even if you have other types of advance directives, a CPR Directive is strongly recommended if you do not want to be resuscitated. Colorado law does not require that a specific CPR Directive form be used and copies, fax-es, and scans of the form are also valid. A template prepared and approved by the Colorado Department of Public Health and Environment appears on the reverse side of this fold.

If you do sign a CPR directive, you should keep the form handy and visible so that emergency personnel or anyone else trying to help you in an emergency can see the form and understand your wishes. At home, place the CPR directive in a clearly marked envelope on your refrigerator, by your bedside, or by your front door. If you are out and about, carry one in your purse or wallet. A CPR alert bracelet or necklace can be ordered from Award and Sign Connection, www.AwardAndSign.com, 303-799-8979, or MedicAlert Foundation, www.MedicAlert.org, 888-633-4298.

CPR DIRECTIVES AND MINORS

After a physician issues a Do Not Resuscitate order for a minor child—and only then—the parents of the minor, if married and living together, or the custodial parent or the legal guardian may execute a CPR Directive for the child.

A court order might appoint a guardian to make medical care and treatment decisions or to manage the ward's financial affairs. A court might appoint a limited guardian to provide particular services for a specific length of time. Generally the duties of a guardian are to decide where the ward should live; to arrange for necessary care, treatment, or other services for the ward; and to see that the basic daily personal needs of the ward are met, including food, clothing and shelter.

Any person aged 21 or over, or an appropriate agency, may be appointed as a guardian. Frequently, guardians are members of the ward's family or close friends of the ward, but professional senior care managers and some county departments of Adult Protective Services may also serve as guardians.

Guardianship can be shared by more than one individual; for instance, one person handling medical decisions and another financial. A guardian is not required to provide for a ward out of his or her own money, nor is he or she required to live with the ward. In addition, a guardian is not responsible for a ward's behavior. It is important to know that, except in emergency situations, the court process to appoint a guardian may take several months.

The Medical Orders for Scope of Treatment (MOST) form is a 1-page, 2-sided document that summarizes in check-box style choices for key life-sustaining treatments including CPR, general scope of treatment, antibiotics, and artificial nutrition and hydration. For each type of treatment, the patient may refuse treatment, request full treatment, or specify limitations. The MOST is primarily intended for use by chronically or seriously ill persons in frequent contact with healthcare providers, or already living in a nursing facility. It is completed by the patient or authorized decision maker along

CPR Directive

A CPR (CARDIO-PULMONARY RESUSCITATION) DIRECTIVE allows you—or your agent, guardian, or Proxy Decision Maker on your behalf—to refuse resuscitation. CPR is an attempt to revive someone whose heart and/or breathing has stopped by using special drugs and/or machines or by firmly and repeatedly pressing the chest. If you have a CPR Directive and your heart and/or lungs stop or malfunction, your consent to CPR is assumed. However, if you have a CPR Directive refusing resuscitation, and your heart and/or lungs stop or malfunction, then paramedics and doctors, emergency personnel or others will not press on your chest or use breathing tubes, electric shock, or other procedures to get your heart and/or lungs working again.

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(CPR Directive continued)

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(continued)
YOUR RIGHT TO MAKE HEALTH CARE DECISIONS is provided through the Colorado Hospital Association as a public service to the community.

This booklet informs you about your right to make healthcare decisions, including the right to accept or refuse medical treatment.

It provides you with ready-to-use forms on which to record your decisions about medical treatment and your choice of the person you want to make decisions for you when you cannot.

These forms, and any written instructions you make ahead of time about your medical treatment, are called advance directives. This booklet explains the following advance directives and related subjects:

- Substitute Decision Makers: Medical Durable Power of Attorney, Proxy Decision Maker, Guardians
- Living Will
- Cardiopulmonary Resuscitation (CPR Directive)
- Medical Orders for Scope of Treatment

FEDERAL LAW REQUIRES THAT YOU MUST BE GIVEN information on advance directives at the time you are admitted by any hospital, nursing home, HMO, hospice, home health care, or personal care program that receives federal funds (Medicare). You must also be given written information on policies of that facility or provider concerning advance directives.

If your advance directive conflicts with the facility's policy or a particular healthcare professional's moral or religious views, the facility or professional must transfer you to the care of another which will honor your advance directives.

You are not required to have advance directives in order to receive care and treatment, or for admission to a facility. You must only be informed about them. Whether or not you have advance directives, you will receive the medical care and treatment you need.

The advance directive forms in this booklet are specific to Colorado. If you spend a lot of time in another state, you should find out if your Colorado advance directives will be honored there. You may need to complete a separate set of advance directives according to the laws of that other state.
Your Right to Make Healthcare Decisions

Accepting Medical Treatment
Refusing Medical Treatment
Living Wills
Resuscitation Directives
Substitute Decision Makers
Medical Guardians
Includes these forms:
- Medical Power of Attorney
- Living Will
- CPR Directive

For more information or downloadable versions of the forms included in this booklet visit www.ColoradoAdvanceDirectives.com

For help or more information about completing the forms, contact your local physician, hospital, senior group, attorney, or any of the organizations below:

- Colorado Advance Directives Consortium
- Colorado Bar Association
- Colorado Department of Public Health and Environment
- Colorado Department of Social Services
- Colorado Hospital Association
- Colorado Medical Society
- Legal Aid Society
- The Legal Center for Persons With Disabilities
- ...or a licensed healthcare facility.

Single copies of this booklet are available at no cost from the Colorado Hospital Association, 720-489-1630

To order multiple copies contact:

Progressive Services, Inc.
1925 S. Rosemary Street, #H, Denver, CO 80231
303-923-0000
Fax 303-923-0001
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### Medical Durable Power of Attorney for Healthcare Decisions

#### I. Appointment of Agent and Alternates

1. **Declanant, hereby appoint:**

   **Name of Agent**

   **Agent’s Best Contact Telephone Number**

   **Agent’s email or alternative telephone number**

   **Agent’s home address**

   as my Agent to make and communicate my healthcare decisions when I cannot. This gives my Agent the power to consent to, or refuse, or stop any healthcare, treatment, service, or diagnostic procedure. My Agent also has the authority to talk with healthcare personnel, get information, and sign forms as necessary to carry out those decisions.

If the person named above is not available or is unable to communicate or make decisions, in order to make sure your wishes are communicated, you can appoint a substitute decision maker. The substitute decision maker must sign the document on your behalf.

**Name of Alternate Agent #1**

**Agent’s Best Contact Telephone Number**

**Agent’s email or alternative telephone number**

**Agent’s home address**

**Name of Alternate Agent #2**

**Agent’s Best Contact Telephone Number**

**Agent’s email or alternative telephone number**

**Agent’s home address**

#### II. When Agent’s Powers Begin

By this document, I intend to create a Medical Durable Power of Attorney which shall take effect either (initial one):

- **(initials) Immediately upon my signature.**
- **(initials) When my physician or other qualified medical professional has determined that I am unable to make my own decisions.**

#### III. Instructions to Agent

My Agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way. If I have not expressed a choice about the decision or healthcare in question, my Agent shall base his or her decisions on what he or she, in consultation with my healthcare providers, determines is in my best interest. I also request that my Agent, to the extent possible, consult me on the decisions and make every effort to enable my understanding and find out my preferences.

State here any desires concerning life-sustaining procedures, treatment, general care and services, including any special provisions or limitations:

**Signature of Declanant**

**Date**

Pursuant to Colorado Revised Statute 15–14.503–509
Addendum to Medical Durable Power of Attorney — recommended, not required

1. Signature of the Appointed Agent

Although not required by Colorado law, my signature below indicates that I have been informed of my appointment as a Healthcare Agent under Medical Durable Power of Attorney for (name of Declarant)

I am at least eighteen (18) years old. I accept the responsibilities of that appointment, and I have discussed with the Declarant his or her wishes and preferences for medical care in the event that he or she cannot speak for him- or herself.

I understand that I am always to act in accordance with his or her wishes, not my own, and that I have full authority to speak with his or her healthcare providers, examine healthcare records, and sign documents in order to carry out those wishes. I also understand that my authority as a Healthcare Agent is only in effect when the Declarant is unable to make his or her own decisions and that it automatically expires at his or her death.

If I am an alternate Agent, I understand that my responsibilities and powers will only take effect if the primary Agent is unable or unwilling to serve.

Primary Agent’s Signature

Printed Name

Date

Alternate Agent #1 Signature

Printed Name

Date

Alternate Agent #2 Signature

Printed Name

Date

2. Signature of Witnesses and Notary

The signature of two witnesses and a notary are not required by Colorado law for proper execution of a Medical Durable Power of Attorney; however, they may make the document more acceptable in other states.

This document was signed by (name of Declarant) in our presence, and we, in the presence of each other, and at the Declarant’s request, have signed our names below as witnesses. We are at least eighteen (18) years old.

Signature of Witness

Printed Name

Address

Signature of Witness

Printed Name

Address

Notary (optional)

State of __________________________

County of _________________________

Notary (optional)

State of __________________________

Address

Notary Public

Pursuant to Colorado Revised Statute 15-14.503—509

FEDERAL AND COLORADO STATE LAW both say that competent adults (those able to make and express decisions) have the right to:

- Make known their wishes regarding medical treatment in advance of needing the treatment.
- Refuse or accept medical treatment at any time for any reason, even during emergency medical personnel.
- Keep your advance directives up to date.
- Keep your advance directives up to date to reflect any change in your mind at any time about anything you have written in an advance directive.

If you have advance directives from another state, they may still be valid in Colorado. However, it is recommended that you prepare new advance directives under Colorado law. If you do not, your prior directives may no longer be valid in Colorado.
I. DECLARATION

I, ______________________________________________,

am at least eighteen (18) years old and able to make and communicate my own decisions. It is my direction that the following instructions be followed if I am diagnosed by two qualified doctors to be in a terminal condition or Persistent Vegetative State.

A. Terminal Condition

If at any time my physician and one other qualified physician certify in writing that I have a terminal condition, and I am unable to make or communicate my own decisions about medical treatment, then:

1. Life-Sustaining Procedures (initial one)

________________________   (Initials) I direct that all life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

________________________   (Initials) I direct that life-sustaining procedures shall be continued for/until (state timeframe or goal):

2. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

________________________   (Initials) Artificial nutrition and hydration shall not be continued.

________________________   (Initials) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

________________________   (Initials) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

B. Persistent Vegetative State

If at any time my physician and one other qualified physician certify in writing that I am in a Persistent Vegetative State, then:

1. Life-Sustaining Procedures (initial one)

________________________   (Initials) I direct that life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

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If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

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________________________   (Initials) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

________________________   (Initials) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

II. OTHER DIRECTIONS

Please indicate below if you have attached to this form any other instructions for your care (initial one):

________________________   (Initials) Yes, I have attached other directions.

________________________   (Initials) No, I do not have any other directions.

III. RESOLUTION WITH MEDICAL POWER OF ATTORNEY (initial one)

________________________   (Initials) My Agent under my Medical Durable Power of Attorney shall have the authority to override any of the directions stated here, whether I signed this declaration before or after I appointed that Agent.

________________________   (Initials) My directions as stated here may not be overridden or revoked by my Agent under Medical Durable Power of Attorney, whether I signed this declaration before or after I appointed that Agent.

Pursuant to Colorado Revised Statute 15–18.101–113
Advance Directive for Surgical / Medical Treatment (Living Will) (continued)

IV. CONSULTATION WITH OTHER PERSONS

I authorize my healthcare providers to discuss my condition and care with the following persons, understanding that these persons are not empowered to make any decisions regarding my care, unless I have appointed them as my Health-care Agents under Medical Durable Power of Attorney.

Name

Relationship


V. NOTIFICATION OF OTHER PERSONS

Before withholding or withdrawing life-sustaining procedures, my healthcare providers shall make a reasonable effort to notify the following persons that I am in a terminal condition or Persistent Vegetative State. My healthcare providers have my permission to discuss my condition with these persons. I do NOT authorize these persons to make medical decisions on my behalf, unless I have appointed one or more of them as my Agent(s) under Medical Durable Power of Attorney.

Name

Telephone number or email

VI. ANATOMICAL GIFTS

(Initials) I wish to donate my (check one or both)
☐ organs and/or ☐ tissues, if medically possible.

(Initials) I do not wish donate my organs or tissues.

VII. SIGNATURE

I execute this declaration, as my free and voluntary act, this day of _________________________, 20____.

Declarant signature

VIII. DECLARATION OF WITNESSES

This declaration was signed by (name of Declarant) in our presence, and we, in the presence of each other, and at the Declarant’s request, have signed our names below as witnesses. We did not sign the Declarant’s signature. We are not doctors or employees of the attending doctor or healthcare facility in which the Declarant is a patient. We are neither creditors nor heirs of the Declarant and have no claim against any portion of the Declarant’s estate at the time this declaration was signed. We are at least eighteen (18) years old and under no pressure, undue influence, or otherwise disqualifying disability.

Signature of Witness

Printed Name

Address

Signature of Witness

Printed Name

Address

Notary (optional)

State of __________________________

County of ________________________

SUBSCRIBED and sworn to before me by _______________________, the Declarant, and ________________________, witnesses, as the voluntary act and deed of the Declarant this day of _________________________, 20____.

Notary Public

My commission expires: _________________________

Pursuant to Colorado Revised Statute 15–18.101–113
Patient’s or Authorized Agent’s Directive to Withhold Cardiopulmonary Resuscitation (CPR)

This template is consistent with rules adopted by the Colorado State Board of Health at 6 CCR 1015-2

**Patient’s Information**

Patient’s Name ___________________________ (Printed Name)

If Applicable Name of Agent/Legally Authorized Guardian/Parent of Minor Child ___________________________ (Printed Name)

Date of Birth ______/____/______ Gender □ Male □ Female Eye Color ___________ Hair Color ___________

Race Ethnicity □ Asian or Pacific Islander □ Black, non-Hispanic □ White, non-Hispanic
□ American Indian or Alaska Native □ Hispanic □ Other

If Applicable- Name of hospice program/provider ______________________________________________________________________________________

**Physician’s Information**

Physician’s Name ___________________________ (Printed Name)

Physician’s Address ______________________________________________________________________________________

Physician’s telephone ( ) _____________ Physician’s Colorado License # _____________

**Directive Attestation**

Check **ONLY** the information that applies:

Patient □ I am over the age of 18 years, of sound mind and acting voluntarily. It is my desire to initiate this directive on my behalf. I have been advised that as a result of this directive, if my heart or breathing stops or malfunctions, I will not receive CPR and I may die.

Authorized Agent/Legally Authorized Guardian/Parent of Minor Child □ I am over the age of 18 years, of sound mind, and I am legally authorized to act on behalf of the patient named above in the issuance of this directive. I have been advised that as a result of this directive, if the patient’s heart or breathing stops or malfunctions, the patient will not receive CPR and may die.

Tissue Donation □ I hereby make an anatomical gift, to be effective upon my death of:

□ Any needed tissues
□ The following tissues □ Skin □ Cornea □ Bone, related tissues and tendons

I hereby direct emergency medical services personnel, health care providers, and any other person to withhold cardiopulmonary resuscitation in the event that my/the patient’s heart or breathing stops or malfunctions. I understand that this directive does not constitute refusal of other medical interventions for my/the patient’s care and comfort. If I/the patient am/is admitted to a healthcare facility, this directive shall be implemented as a physician’s order, pending further physician’s orders.

□ Signature of Patient
□ Authorized Agent/Legally Authorized Guardian/Parent of Minor Child

Date ___________________________ Date ___________________________

Physician Signature

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A MOST form is not included in this directive. Your family will have the information that applies:

- **Advance Directive** Attestation: A section of the form is dedicated to attestation, allowing the patient or their agent to affirm their understanding and agreement with the content of the directive. It is a legally binding document.

- **Physician Information**: Includes the name, address, and contact information of the physician who has reviewed and attested to the directive. This ensures that the directive is respected by healthcare providers.

- **Tissue Donation**: Specifies the types of tissues that are to be donated in the event of cardiac arrest, providing an anatomical gift for medical use.

- **Directive Attestation**: Requires signatures from both patient and authorized agent, ensuring that the directive is legally valid and binding.