



**Down East
COMMUNITY**
Our Health, Our Hospital

ADVANCED DIRECTIVE AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECLARATION

I, _____, being of sound mind, willfully and voluntarily make this declaration to be followed if I become without capacity or incompetent. This declaration reflects my firm and settled commitment regarding the forms of treatment for the circumstances indicated below.

I do / do not direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of my dying, if I should be in a terminal condition or in a state of permanent unconsciousness.

I do / do not direct that treatment to be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the conditions described above, I feel especially strongly about the following forms of treatment:

- I do / do not want cardiac resuscitation.
- I do / do not want mechanical respiration.
- I do / do not want tube feeding or any other invasive form of nutrition (food) or hydration (water).
- I do / do not want blood or blood products.
- I do / do not want any form of surgery or invasive diagnostic tests.
- I do / do not want kidney dialysis.
- I do / do not want antibiotics.
- I do / do not want to donate my organs at my death.
- I do / do not want to designate another person as my agent to make medical decisions for me when my doctor decides I am not able to make my own health care decisions.
- I do / do not want my agent to make health care decision for me right away.

You have the right to cancel or replace this form at any time. Please inform each person and place you gave a copy to that you have cancelled this form and provide them with a copy of any new form you may fill out.

My Name (please print): _____

My Address: _____

My Phone: _____

My Birthdate: _____

My Primary Doctor: _____

Doctors Phone: _____

I choose the following person as my agent to make health care decisions for me:

Name: _____

Title or Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

If I cancel by first choice for agent or if my first choice is not able to be my agent, my second choice for agent is listed here:

Name: _____

Title or Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____

We suggest that you discuss this document with your family physician, your agent(s), and family members to ensure that they understand your wishes and are willing to carry them out. Make sure to give a copy to all of your health care providers and your local hospital.

Copies of this form have been given to the following:

OTHER WISHES

Relief from pain: I have checked below my choices about pain relief:

I want treatment for relief of pain or discomfort to be given at all times, even if it shortens the time until my death or makes me unconscious or unable to do other things.

These are my wishes about relief or pain or discomfort:

Any other wishes that you have should be written here.

If you have filled out this form, you must sign and date it. You must also have two (2) other people sign as witnesses. **You do not need to have an Advanced Directive form notarized to make it legal in Maine. However, if you plan to travel out of the state or reside out of state seasonally, it is recommended that you obtain a notarization of this document.**

Sign and date the form here:

Sign your name: _____

Print your name here: _____

Address: _____

Date: _____

First Witness:

Sign your name: _____

Print your name here: _____

Address: _____

Date: _____

Second Witness:

Sign your name: _____

Print your name here: _____

Address: _____

Date: _____

Notary Acknowledgment; Then personally appeared the above named _____ to me well know and acknowledged this Advanced Directive, including power of attorney for healthcare, and his/her free act and deed before me.

Date: _____ State of: _____ Commission Exp: _____

Print Name: _____ Signature: _____

EMS DNR FORM

Advanced Directive Addendum Form

This form is to be completed by your Primary Care Physician with the intention of complying with the EMS guidelines followed by all EMS staff when an ambulance is dispatched to transfer you to the hospital.

*These providers are only allowed to honor your Do Not Resuscitate (DNR) order when it is signed by a physician annually (**defined as dated within 1 year of the current treatment/transfer request**).*

To allow your EMS provider to honor your Do Not Resuscitate (DNR) please have your Primary Care Physician complete this page of your document.

I have discussed the patients documented wishes for medical treatment as defined in his/her Advanced Directive and the patient desires a DNR status. We both agree that the document adequately reflects his/her firm and settled commitment regarding the forms of treatment desired.

Physician Signature

Date

Patient Signature or Healthcare POA

Date

NOTE: Be sure to have a copy of your Advanced Directive, including this completed page, available in your home to provide to the EMS provider when they arrive to transfer you to the hospital. Otherwise, the EMS provider can not honor this request.