PERSONAL DECLARATION OF VALUES

Because death is a part of every life, and can come at any time, there are several reasons for giving it careful thought. You will handle it better if it is on your own terms, and it will be very helpful to those who care about you if they know your preferences. You may use this as a guide to completing your Advance Directives.

These questions are worth exploring alone, with loved ones, and with your Agents:

- Have you accepted the fact that you are going to die one day?
- Is it death, or the process of dying, that is of most concern to you?
- Have you experienced a friend or relative's death, or known someone who simply wanted to find release from pain and suffering through death?
- Have you given thought to the meaning of life? If yes - a meaning in general, or the specific meaning of your own life at any given moment?
- How would you feel if at some point you felt that your life had lost all meaning?
- Are you able to savor the small things in daily life, things that you perhaps used to take for granted?
- What are some of the things in life that create warm recollections?

Chronic or terminal illness can cause many of the following:

- Intractable symptoms: pain, nausea, fatigue, anorexia, anxiety, confusion, incontinence, difficulty swallowing or breathing, sleeplessness or sleepiness
- Indignities such as helplessness, loss of bowel and bladder control, inability to wash, dress, eat, walk, or transfer to a toilet or commode
- With dementia, loss of self, memory, and ability to communicate, with radical personality changes such as repeated angry outbursts
- The anguish of those you love as they watch you deteriorate
- Depletion of your life savings to medical or nursing home costs
- Simple inability to enjoy living, given the conditions of life and health

Rate what is important to you with 5 being the most important, and 1 being the least important:

	1	2	3	4	5
Knowing the truth about my diagnosis and prognosis					
Taking part in decision-making involving my healthcare					
Having my healthcare Agent participate in decisions if I am unable to decide for myself					
Living at home, with help if necessary					
Living in a retirement or care center					
Using every medical intervention necessary to stay alive					
Letting nature "take its course"					
Being comfortable and pain free					

	1	2	3	4	5
Maintaining a satisfactory quality of life					
Maintaining my dignity					
Maintaining my privacy					
Maintaining mental capacity					
Being able to pursue my hobbies					
Having physical mobility					
Being able to care for myself					
Maintaining my eyesight					
Maintaining my hearing					
Being able to communicate					
Having hospice care at home (or care center) toward the end					
Being hospitalized toward the end					
Managing my finances					
Controlling health care costs					
Leaving assets for family, friends, charities, etc.					
Avoiding being a burden on others					

Other thoughts and feelings regarding medical treatments and end-of-life wishes:

MAKING YOUR WISHES KNOWN

Recent studies indicate the single most powerful thing a person can do to improve the chance for a peaceful death is --- simply and courageously --- to talk about it. Effective communication with those who will be called upon to make decisions on your behalf is key to the likelihood that your wishes are carried out. It is never too early to get started.

When to have the Conversation

- DEATH is the elephant in the room. Even if no one mentions it, everyone knows it's there.
- How do you begin to talk about death? One approach is to purposefully create time to initiate the conversation. You might choose a family gathering on a holiday or at a special event such as your birthday. Or you might decide it would be better to initiate individual conversations with family members before having a group discussion.
- Another approach is to stay alert to spontaneous opportunities. Introduce the topic of end-of-life wishes when a particular subject arises, such as concerns about losing various aspects of your independence.

What to Talk About

- Your discussions should include how you would want to be treated in a variety of situations, as identified in your Personal Declaration of Values. Those close to you need to know what you would want if you were living with physical pain, disability, terminal illness, dementia or debilitating chronic illness.
- Consider who you want to advocate for you if you can no longer make your own decisions, and let people know who those agents will be.
- Be sure to ask each person you talk with if they are comfortable with your choices.

Conversation Starters

With your family:

- "It's important for me to be able to talk honestly with you about my concerns and wishes if I ever become seriously ill or unable to speak for myself..."
- "I need to talk with you about my advance directives ..."

- "I want to make sure that I get the best care possible, and the type of care that I want, so there are things we should talk about..."

- "I want to make it as easy as possible for my family to make medical decisions on my behalf if I ever become incapable of communicating my wishes..."

- "If you are ever in a position where you need to make health care decisions for me, it will be most helpful to you if you know what I really want..."

With your health care provider:

- "At the end of life, medical treatments may cause additional suffering along with the hope of prolonging life. My feelings about that are... "

- "I love so much about life – being active and independent, having my mental faculties, enjoying my family. If none of that were possible anymore, "I'd want ..."

- "I have some concerns about end-of-life decisions. I want to be sure you will fully explain all procedures, treatments, alternatives and risks to me and my agent..."

Conclusion

It is important to think through your concerns and how they affect your wishes for end-of-life care, and to communicate those wishes to your health care provider and your loved ones. If they ever have to make decisions on your behalf, that difficult task will be made easier by being confident that they know your wishes. You relieve them of the burden of guessing what you would choose when you make your preferences clear to everyone well ahead of a medical crisis. Other people who need to know about your end-of-life concerns and wishes could include other family members, friends, other medical caregivers, your attorney, and clergy.

Talk with your family and personal health care provider about specific treatments that could come up, particularly regarding any current medical condition. In conversation with your health care provider or prospective agents, you may realize they do not support your wishes. You have the right to change health care providers, and to name health care agents who do support your desires.

If you anticipate that some family members may strongly disagree with your choices, communicate directly (verbally and in writing) with those you anticipate will not support your wishes, and be clear that you do not want them involved in decision making and why.

COLORADO ADVANCE DIRECTIVE

Medical Durable Power of Attorney and Declaration as to Medical or Surgical Treatment

Being of sound mind, I appoint the below Agents and make this Declaration for use at any future time when I am not able to participate in necessary medical decisions. This document supersedes all previous Advance Directives signed by me.

This document shall be governed by the laws of the State of Colorado in all respects, including its validity, construction, interpretation, and termination. However, I intend for this document to be honored in any jurisdiction in which it may be presented and for any such jurisdiction to refer to Colorado law to interpret and determine the validity of this document and any of the powers granted under this document.

Photocopies of this document shall be as effective as the original. I specifically direct my Agent to have photocopies of this document placed in my medical records.

Part One: Medical Durable Power of Attorney

I, _____,
Print name

of _____,
Address

hereby appoint, to serve as my Agent and to exercise the powers set forth below:

_____
Print name, address, phone and email

_____

I, the undersigned, accept appointment as Agent under this Medical Durable Power of Attorney and Directive for Medical or Surgical Treatment.

_____,
Print name

_____,
Signature

If my Primary Agent is not available, or unable or unwilling to serve, I hereby designate as my First Alternate Agent:

_____
Print name, address, phone and email

_____

I, the undersigned, accept appointment as Alternate Agent under this Medical Durable Power of Attorney and Directive for Medical or Surgical Treatment.

_____,
Print name

_____,
Signature

If my Primary and First Alternate Agent are not available, or unable or unwilling to serve, I designate as my Second Alternate Agent:

_____
Print name, address, phone and email

_____

I, the undersigned, accept appointment as Alternate Agent under this Medical Durable Power of Attorney and Directive for Medical or Surgical Treatment.

_____,
Print name

_____,
Signature

ACTIVE DATE AND DURABILITY

This Medical Durable Power of Attorney shall be effective upon, and only during, any period of disability or incapacity in which, in the opinion of my attending healthcare professional, I am unable to make or communicate responsible decisions regarding medical treatment or healthcare for myself.

AGENT'S AND ALTERNATE AGENTS' POWERS

I grant to my Agent and Alternate Agent(s) full authority to make decisions for me regarding medical and psychological treatment. In exercising this authority, my Agents shall follow my desires as stated in my Declaration as to medical or surgical treatment. In making decisions, my Agents shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate rationally.

If my Agents cannot determine the choice I would want made, then my Agents shall make a choice for me based upon what my Agents believe to be in my best interest. My Agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below. Accordingly, my Agents are authorized as follows:

- To consent to, refuse, or withdraw consent to, any and all types of medical and psychiatric care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect bodily function, including (but not limited to) artificial respiration, artificial nourishment and hydration, and cardiopulmonary resuscitation.

- To take any other action necessary to implement my preferences as expressed herein or elsewhere, including (but not limited to) granting any waiver or release from liability required by any hospital, healthcare professional, or other healthcare provider; signing any documents relating to acceptance or refusal of treatment or discharge from a facility against medical advice; and pursuing any legal action in my name, and at my own or my estate's expense, to enforce compliance with my wishes as determined by my Agent, including claims for actual or punitive damages for any such failure to comply.

- To have access to my medical records and information to the same extent that I am entitled, including the right to disclose the contents to others as appropriate.

- To authorize my admission to or discharge from any hospital, long term care facility, assisted living, or similar care facility or service.

- To contract on my behalf for any healthcare related service or facility, without my Agent's incurring personal financial liability for such contracts.

- To retain and discharge medical, hospice, social service and other support personnel responsible for my care.

- To make anatomical gifts upon my death as follows. *(Initial those that apply)*

  - _____ Organ, tissue, and/or bone donations for the limited purpose of transplantation to such persons or organizations as my agent shall deem appropriate, and to execute such papers and do such acts as shall be necessary and appropriate with such gifts.

  - _____ Anatomical gifts (full body) for the purpose of medical research to such persons and organizations as my agent shall deem appropriate, and to execute such papers and do such acts as shall be necessary and appropriate in connection with such gifts.

  - _____ I do NOT authorize my agents to make any anatomical gifts on my behalf.

- To follow my instructions for: *(Initial those that apply)*

  _____ Cremation _____ Burial
  _____ Funeral _____ Memorial Service _____ Other

  I have prearranged my cremation or burial. The papers are located: _____

ACCESS TO MEDICAL RECORDS AND OTHER PERSONAL INFORMATION

My Agents shall have the power to request, receive, review and release any information, including medical and hospital records, drug-and-alcohol treatment information, mental health information, and other data having special protections under the law, specifically including the Health Insurance Portability and Authorization Act of 1996 (HIPAA), regarding my physical or mental health; to execute any releases, waivers, insurance forms, or other documents that may be requested in order to obtain such information; or to obtain government assistance or insurance payment for any service rendered to me or for my benefit. Each person nominated to be my Agent shall specifically be authorized to receive all personal health information and documents necessary to determine my incapacity as if such persons were already acting as my Agent.

GRANTING RELEASES

My Agents, on behalf of me, my heirs, and my estate, shall have the power to grant waivers or releases from liability to healthcare providers and other persons or covered entities (as defined under HIPAA) involved in providing healthcare services for me or maintaining my protected health information and other healthcare records, who act in reliance on instructions given by my Agents for the purpose of carrying out the provisions of this document.

NOMINATION OF GUARDIAN

If a guardian should need to be appointed, I nominate my Agent, or an Alternate Agent named above, if my Agent is unable or unwilling to serve.

Part Two. Declaration as to Medical or Surgical Treatment (Living Will)

1. If I have a **TERMINAL INJURY, ILLNESS OR DISEASE**, or am or will be in a **PROLONGED and/or IRREVERSIBLE COMA**, or am in a **PERSISTENT VEGETATIVE STATE**; or am in an **ADVANCED STAGE OF PROGRESSIVE DEMENTIA**; and if my healthcare professionals certify that there is no reasonable probability of recovery from these conditions; I direct that the procedures I have initialed be initiated and continued (initial "Yes"); initiated, but discontinued if not effective (Initial "Trial"); or withheld or withdrawn (initial "No"). ***I am aware that withholding or withdrawing any of these procedures may hasten my death.***

	Yes	Trial*	No
No life sustaining treatments – comfort care only			
Medications to control pain			
Cardiopulmonary resuscitation (CPR)			
Hospitalization			
Intensive care unit admission			
Artificial mechanical breathing (ventilator)			
Kidney dialysis			
Chemotherapy			
Surgery			
Invasive diagnostic tests or procedures			
Blood transfusions			
Antibiotics to treat infection			
Hospice care: _____home, _____facility			
Other:			

**A trial period (usually 3-5 days) means that doctors will see if a therapy quickly reverses my condition.*

2. Specifically with regard to NOURISHMENT AND HYDRATION, I have initialed the following items with which I agree:

If I am unconscious and my healthcare providers have established that there is no reasonable likelihood that I will ever return to a conscious state, **or** if I have advanced progressive dementia and am no longer able to feed myself, I declare my wishes to:

_____be offered spoon feeding, but never be fed forcefully
_____stop eating and drinking by mouth
_____accept _____intravenous or _____tube feeding for ____nutrition and/or ____hydration
_____refuse _____intravenous or _____tube feeding for ____nutrition and/or ____hydration

Other instructions:

_____

_____

_____

_____

_____

_____

_____

Part Three. Exculpation, Revocation, Resignation and Severability

EXCULPATION

A. My Agent and my Agent's estate, heirs, successors, and assigns are hereby released and forever discharged by me, my estate, heirs, successors, and assigns from all liability and from all claims or demands of all kinds arising out of the acts or omissions of my Agent. No person who relies in good faith upon any representations by my Agent or Alternate Agents shall be liable to me, my estate, my heirs or my successors or assigns for recognizing the Agent's authority.

B. Any healthcare professional or other individual acting on my behalf is authorized and directed to follow these instructions. No healthcare professional signing a certificate of terminal condition and no healthcare professional, hospital or hospital personnel withholding or withdrawing life-sustaining procedures in compliance with this declaration, in the absence of actual knowledge of revocation or fraud, misrepresentation, or improper execution, shall be subject to civil liability, criminal penalty, or licensing sanctions therefore. On behalf of myself, my Agents, my family and my heirs and devisees, I hereby release any person who acts in reliance on the foregoing sentence from any claim or liability for any injury to me or arising by reason of my death.

REVOCATION AND RESIGNATION

I reserve the right to revoke or amend this document and to substitute other Agents in place of those designated herein while I am mentally competent. Amendments or revocation shall only be made in writing by me personally, and shall replace the original and all copies of this document.

My agent and any Alternate Agent may resign by the execution of a written resignation delivered to me, or, if I am mentally incapacitated, by delivery to any person in charge of my care and custody.

SEVERABILITY

If any part of any provision of this document shall be invalid or unenforceable under applicable law, such part shall be ineffective to the extent of such invalidity only, without in any way affecting the remaining provisions of this document.

SIGNATURES

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND THE EFFECT OF THIS GRANT OF POWERS TO MY AGENT. I AM OF SOUND MIND AND KNOWINGLY AND WILLFULLY EXECUTE THIS DOCUMENT.

I sign my name to this Medical Durable Power of Attorney and Declaration as to Medical or Surgical Treatment on this _____ day of _____, 20_____

Signature _____

Home address _____

WITNESSES' STATEMENT

I do hereby declare that the Principal (the person who has signed or acknowledged this document), _____, has signed or acknowledged this Medical Durable Power of Attorney and Declaration as to Medical / Surgical Treatment Document in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

To the best of my knowledge, I am not a creditor of the Principal nor entitled to any part of his or her estate under a will now existing or by operation of law.

Witness No. 1

Signature: _____Date: _____

_____
Print name, address, phone and email

_____

Witness No. 2

Signature: _____Date: _____

_____
Print name, address, phone and email

_____

Notarizing is optional. If you wish to have this document notarized, use the following form:

STATE OF COLORADO

CITY _____ COUNTY _____

Subscribed and sworn to before me by _____,

(the Principal), as a voluntary act, this _____ day of_____, 20_____.

Notary Public _____

Stamp:

WORKSHEET FOR SELECTING PRIMARY AND ALTERNATE AGENTS

Legal Requirements:

- Must be at least 18 years old
- Must be capable of making sound decisions

Questions to Consider:

- Will they respect your values?
- Are they able to stand up for your wishes?
- Will they be able to make difficult and possibly emotional decisions?
- Do they live nearby?
- Are they willing to talk about death?

PRIMARY AGENT

_____

_____

ALTERNATE AGENTS

_____

_____

_____

_____

COMPLETING YOUR ADVANCE DIRECTIVES

1. Have "The Conversation" with your Agents.
2. Complete filling out your Advance Directives.
3. Have your Agents sign on pages 3 and 4, indicating that they agree to serve as Agents.
4. Sign your Advance Directives with two witnesses present, and a notary if that is your choice.

What To Do with Your Advance Directives

1. Give copies to:
   - Agents and Alternative Agents
   - Doctors – both your GP and any specialists you see regularly
   - Hospital, assisted living facility and/or nursing home medical records departments
   - Any other people you want to be informed of your wishes

2. Make a list of everyone to whom you have given a copy and keep it with the original.

3. Put the original in a safe, but easily accessible place – NOT a safe deposit box – and tell your Agents where it is.

4. Complete an "In Case of Emergency" info card indicating that you have Advance Directives, and giving contact information for your Agents … and keep it with you at all times.

5. Put your Agent and Alternate Agents on your cell phone as ICE (In Case of Emergency) contacts. You can also put MDPOA by their names; i.e., ICE 1 MDPOA Joan Smith; ICE 2 MDPOA Sam Jones; ICE 3 MDPOA Sandra Wilson.

6. Plan to review and update your Advance Directives at least yearly. If changes are made, make new copies, have them witnessed/notarized, and destroy all the old ones.

In Case of Emergency: Smart Phone Apps

Many free and low-cost apps are available for iPhones and android phones. If you have an iPhone 4s or later, a Health app is already included in your standard apps. You can put the fact that you have advance directives in the information that comes up when the phone is activated.

In Case of Emergency Card

You can also print your personal ICE information on small pieces of paper or cards and keep them in your wallet, your vehicle and your home. It's a good idea to have them laminated to protect them from damage.

Here's a sample of the information to be included on your card. Of course, you can add to or subtract from this format, too.

I am (Name), a US (or other) citizen.
I have (list medical conditions) and take (list prescriptions and OTC drugs)
I have the following allergies (list any)
My blood type is _____

Please notify my Agents, who have copies of my
Medical Durable Power of Attorney and Living Will.
All are on ICE on my cell phone.

#1 to be contacted:
Name
Home Phone
Cell Phone

#2 to be contacted:
Name
Home Phone
Cell Phone

#3 to be contacted:
Name
Home Phone
Cell Phone

Primary Care Physician:
Name
Phone

Be Forewarned:
EMTs state that if Advance Directives are not readily visible (on your refrigerator) or attention called to them immediately, they will do all in their power to save you if 9-1-1 is called.