FAIRFIELD MEMORIAL HOSPITAL

EXCELLENCE IN COMMUNITY HEALTHCARE

ADVANCED DIRECTIVES

INCLUDED IN THIS PACKET:

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- UNIFORM DO-NOT-RESUSCITATE (DNR) PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST)

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ILLINOIS DEPARTMENT OF PUBLIC HEALTH (IDPH)
UNIFORM DO-NOT-RESUSCITATE (DNR-POLST) ADVANCE DIRECTIVE

Guidance for Individuals

The Illinois Department of Public Health (IDPH) Uniform Do-Not-Resuscitate (DNR -POLST) Advance Directive can be used to create a physician order that reflects an individual's wishes about receiving *cardiopulmonary resuscitation (CPR).* The form allows you, in consultation with your health-care professional, to make advance decisions about whether CPR should be administered if your breathing and/or heartbeat stop. CPR, when successful, restores heartbeat and breathing. The completed form is intended to be honored across various settings, including hospitals, nursing homes, and by emergency medical services personnel in your residence or en route to a health-care facility. You should use the IDPH Uniform DNR-POLST Advance Directive to replace the previous DNR forms.

You should complete the IDPH Uniform DNR-POLST Advance Directive only after extensive discussion about treatment preferences with your immediate family members and your health-care professional. Items for discussion with your health-care professional should include your preferences regarding administration of CPR if your heartbeat and/or breathing stop, in view of the following:

- **Your personal views**
- **Your medical condition and related medical considerations**
- **Your views regarding use of CPR in the event of an unforeseen accident (such as a car crash or choking on food)**
- **Quality of life issues before and after CPR**
- **Your views regarding use of CPR during surgery or other medical procedure**
- **Your wishes regarding organ donation**
- **Your views regarding use of a mechanical ventilator**

You are not required to consent to a DNR order as a condition of treatment or care. If you become unable to make decisions for yourself, a decision regarding whether you should have a DNR order can be made by your legal representative and your physician.

I. General Considerations

What is a Do-Not-Resuscitate (DNR) order?

A Do-Not-Resuscitate (DNR) order is a medical treatment order that says cardiopulmonary resuscitation (CPR) will not be attempted if your heart and/or breathing stops.

What is cardiopulmonary resuscitation (CPR)?

CPR refers to various medical procedures, such as chest compressions, electrical shocks and insertion of a breathing tube, used in an attempt to restart your heart and/or breathing.

Why are DNR orders issued?

Health-care professionals ordinarily will begin CPR when your heart and/or breathing stop. You may make a choice, however, not to receive CPR under these circumstances. A DNR order states you prefer to be cared for without CPR in the event your heart and/or breathing stops.

Who may have a DNR order?

An adult or an emancipated minor who does not wish to have CPR attempted when his or her heart and/or breathing stops may have a DNR order. The parent or legal guardian of a minor also may request a DNR order for the minor.

Is there a form my physician can use to enter a DNR order?

The Illinois Department of Public Health (IDPH) has developed the "IDPH Uniform Do-Not-Resuscitate (DNR-POLST) Advance Directive" that your physician can use. A DNR order completed on this form should be honored by health-care professionals and providers in health-care facilities, as well as by EMTs and paramedics in your home or en route to a health-care facility. To obtain a copy of the IDPH Uniform DNR-POLST Advance Directive, you may request one from your health-care professional or facility. Copies also are available on the Illinois Department of Public Health's Web site located at www.idph.state.il.us/public/books/advin.htm. Health-care facilities also may have their own form, but this guidance addresses only the IDPH Uniform DNR-POLST Advance Directive.

Where may a DNR order be used?

A DNR order may be used by all health-care professionals and providers. If you choose to use the IDPH Uniform DNR-POLST Advance Directive, it is required by law to be honored in licensed hospitals, in certain licensed long-term care facilities such as nursing homes, and by licensed emergency medical services personnel.

II. Completing and Reviewing the IDPH Uniform DNR-POLST Advance Directive

If I want all resuscitation efforts under all circumstances, do I still have to complete the IDPH Uniform DNR Advance Directive?

No. If you do not have a completed DNR order, CPR should be attempted if your heartbeat and/or breathing stop.

If I do not have a completed DNR order, what will happen if I suffer some type of cardiopulmonary arrest?

Again, CPR should be attempted in the event your heart and/or breathing stop.

Who may provide the consent required on the IDPH Uniform DNR Advance Directive?

Generally, consent may be obtained from you or another person legally authorized to act on your behalf. If you are unable to make your own health-care decisions, a legal guardian, a health-care agent under a health-care power of attorney or a health-care surrogate may consent on your behalf to the DNR order. A parent or legal

guardian typically may grant the required consent for a minor, and emancipated minors also may consent to a DNR order.

Does the IDPH Uniform DNR-POLST Advance Directive require the signature of the person who is consenting to the DNR order?

Yes. You or your legal representative, health-care agent or health-care surrogate must sign the section of the form concerning consent.

Is a witness required for the IDPH Uniform DNR-POLST Advance Directive?

Yes. One individual, 18 years of age or older, must witness your signature or your legal representative's signature granting consent on the IDPH Uniform DNR Advance Directive. A witness may include a family member, friend or health-care worker.

III. Implementing a Completed IDPH Uniform DNR-POLST Advance Directive

Once I have a completed DNR order on an IDPH Uniform DNR-POLST Advance Directive, what medical care will be given to me?

When the DNR order is entered into your medical record, you will continue to receive appropriate medical care. However, if your heartbeat and/or breathing stops, appropriate medical treatment will only be given to you according to your wishes as expressed in the IDPH Uniform DNR-POLST Advance Directive.

Does the cause of the cardiopulmonary arrest matter when invoking my DNR order?

Generally, no. The order generally applies when your heartbeat and/or breathing stop, regardless of what caused the cardiopulmonary arrest. For example, if you go into cardiopulmonary arrest from an accident, and you have a DNR order, your wishes as stated in the order likely will be followed to the extent the order is readily available to the health-care provider.

A DNR order may not be appropriate for you, should you want CPR administered if your heartbeat and/or breathing stop as a result of an accident or during a medical procedure such as surgery. Therefore, it is very important to discuss your wishes with your health-care professional prior to consenting to a DNR order. You and your health care professional might want to consider placing your wishes regarding application of the order in the event of an accident or medical procedure in the portion of the form designated for other instructions.

What if I change my mind about having a DNR order?

You (or your legal representative on your behalf) can change your mind at any time about having a DNR order. The DNR order can be revoked in a variety of ways, such as by writing "VOID" in large letters across the front of the form. If you revoke a DNR order, you also should tell your family members, as well as each health-care professional and provider that has received a copy of the order. You may then choose not to have a DNR order, or you may choose to complete a new DNR order reflecting any changes you wish.

Does my completed DNR order have an expiration date?

No. The order is valid until you revoke it. If you are unable to revoke it, your legal representative may do so.

Must all health-care providers honor my DNR order?

Licensed hospitals, certain licensed long-term care facilities such as nursing homes, and licensed emergency medical services personnel are required by law to honor a DNR order completed on the IDPH Uniform DNR-POLST Advance Directive.

If an ambulance is called to take me to the hospital, should my DNR order be honored by licensed emergency medical services personnel?

Yes, as long as someone provides emergency medical services personnel with a copy of your DNR order, and the order appears to be complete and valid. If a form other than the IDPH Uniform DNR Advance Directive is used, however, there may be barriers to honoring your DNR order.

If I am transferred from one facility to another, should my DNR order be sent with me?

Your DNR order, or a copy of it, should accompany you to the next setting, whether it is a hospital, rehabilitation facility, nursing home or your own home.

Are photocopies of the IDPH Uniform DNR-POLST Advance Directive valid?

Generally, yes. Photocopies of a completed IDPH Uniform DNR-POLST Advance Directive are valid. Each health-care facility, however, may have different policies on whether copies of DNR orders completed on a form other than an IDPH Uniform DNR-POLST Advance Directive are accepted as valid. It is advisable to check with a health-care facility regarding its DNR policy.

Who keeps the completed DNR order?

You should keep the original DNR order with you where you reside, whether at home or on file in your medical record at a long-term care facility and your physician should keep a copy in your medical record. A copy also should be with you if you are transported to a hospital or other health-care facility. If you have a legal guardian, have named an agent under a power of attorney for health-care or have a surrogate (substitute) decision maker, he or she also should have a copy of the order readily accessible.

Are DNR orders ever suspended during surgery or other medical procedures?

Certain health-care providers in Illinois have written policies indicating that a DNR order may be suspended during a surgical procedure after discussion with you or your legal representative.

Further, your wishes regarding applicability of a DNR order during surgery, or in the event of an unforeseen accident (e.g. a car crash or choking on food), may be placed on the form in the space designated for "other instructions".

What other documents might I consider signing to direct my care when I am no longer able to make health-care decisions for myself?

You may choose to make your wishes known by appointing an agent through a power of attorney for health-care or by executing a living will. Read the "Statement of Illinois Law on Advance Directives" for further information regarding the various advance directives available in Illinois. The statement is located on the Illinois Department of Public Health's Web site at www.idph.state.il.us/public/books/advin.htm. You also can

obtain at this Web site the following forms: IDPH Uniform DNR-POLST Advance Directive, Health Care Power of Attorney, Living Will and Mental Health Treatment Preference Declaration.

The Illinois Department of Public Health has provided this guidance document for general informational purposes. Because each individual situation is different and key facts can so often change the outcome, additional questions should be directed to a licensed attorney, as IDPH cannot provide legal advice.

State of Illinois
Illinois Department of Public Health

Illinois Statutory Short Form
Power of Attorney for Health Care

NOTICE TO THE INDIVIDUAL SIGNING THE POWER OF ATTORNEY FOR HEALTH CARE

No one can predict when a serious illness or accident might occur. When it does, you may need someone else to speak or make health care decisions for you. If you plan now, you can increase the chances that the medical treatment you get will be the treatment you want.

In Illinois, you can choose someone to be your "health care agent." Your agent is the person you trust to make health care decisions for you if you are unable or do not want to make them yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of agent in writing. The written form is often called an "advance directive". You may use this form or another form, as long as it meets the legal requirements of Illinois. There are many written and on-line resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing your advance directive.

WHAT ARE THE THINGS I WANT MY HEALTH CARE AGENT TO KNOW?

The selection of your agent should be considered carefully, as your agent will have the ultimate decision-making authority once this document goes into effect, in most instances after you are no longer able to make your own decisions. While the goal is for your agent to make decisions in keeping with your preferences and in the majority of circumstances that is what happens, please know that the law does allow your agent to make decisions to direct or refuse health care interventions or withdraw treatment. Your agent will need to think about conversations you have had, your personality, and how you handled important health care issues in the past. Therefore, it is important to talk with your agent and your family about such things as:

(i) What is most important to you in your life?

(ii) How important is it to you to avoid pain and suffering?

(iii) If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?

(iv) Would you rather be at home or in a hospital for the last days or weeks of your life?

(v) Do you have religious, spiritual, or cultural beliefs that you want your agent and others to consider?

(vi) Do you wish to make a significant contribution to medical science after your death through organ or whole body donation?

(vii) Do you have an existing advance directive, such as a living will, that contains your specific wishes about health care that is only delaying your death? If you have another advance directive, make sure to discuss with your agent the directive and the treatment decisions contained within that outline your preferences. Make sure that your agent agrees to honor the wishes expressed in your advance directive.

WHAT KIND OF DECISIONS CAN MY AGENT MAKE?

If there is ever a period of time when your physician determines that you cannot make your own health care decisions, or if you do not want to make your own decisions, some of the decisions your agent could make are to:

(i) talk with physicians and other health care providers about your condition.

(ii) see medical records and approve who else can see them.

(iii) give permission for medical tests, medicines, surgery, or other treatments.

(iv) choose where you receive care and which physicians and others provide it.

(v) decide to accept, withdraw, or decline treatments designed to keep you alive if you are near death or not likely to recover. You may choose to include guidelines and/or restrictions to your agent's authority.

(vi) agree or decline to donate your organs or your whole body if you have not already made this decision yourself. This could include donation for transplant, research, and/or education. You should let your agent know whether you are registered as a donor in the First Person Consent registry maintained by the Illinois Secretary of State or whether you have agreed to donate your whole body for medical research and/or education.

(vii) decide what to do with your remains after you have died, if you have not already made plans.

(viii) talk with your other loved ones to help come to a decision (but your designated agent will have the final say over your other loved ones).

Your agent is not automatically responsible for your health care expenses.

WHOM SHOULD I CHOOSE TO BE MY HEALTH CARE AGENT?

You can pick a family member, but you do not have to. Your agent will have the responsibility to make medical treatment decisions, even if other people close to you might urge a different decision. The selection of your agent should be done carefully, as he or she will have ultimate decision-making authority for your treatment decisions once you are no longer able to voice your preferences. Choose a family member, friend, or other person who:

(i) is at least 18 years old;

(ii) knows you well;

(iii) you trust to do what is best for you and is willing to carry out your wishes, even if he or she may not agree with your wishes;

(iv) would be comfortable talking with and questioning your physicians and other health care providers;

(v) would not be too upset to carry out your wishes if you became very sick; and

(vi) can be there for you when you need it and is willing to accept this important role.

WHAT IF MY AGENT IS NOT AVAILABLE OR IS UNWILLING TO MAKE DECISIONS FOR ME?

If the person who is your first choice is unable to carry out this role, then the second agent you chose will make the decisions; if your second agent is not available, then the third agent you chose will make the decisions. The second and third agents are called your successor agents and they function as back-up agents to your first choice agent and may act only one at a time and in the order you list them.

WHAT WILL HAPPEN IF I DO NOT CHOOSE A HEALTH CARE AGENT?

If you become unable to make your own health care decisions and have not named an agent in writing, your physician and other health care providers will ask a family member, friend, or guardian to make decisions for you. In Illinois, a law directs which of these individuals will be consulted. In that law, each of these individuals is called a "surrogate".

There are reasons why you may want to name an agent rather than rely on a surrogate:

(i) The person or people listed by this law may not be who you would want to make decisions for you.

(ii) Some family members or friends might not be able or willing to make decisions as you would want them to.

(iii) Family members and friends may disagree with one another about the best decisions.

(iv) Under some circumstances, a surrogate may not be able to make the same kinds of decisions that an agent can make.

WHAT IF THERE IS NO ONE AVAILABLE WHOM I TRUST TO BE MY AGENT?

In this situation, it is especially important to talk to your physician and other health care providers and create written guidance about what you want or do not want, in case you are ever critically ill and cannot express your own wishes. You can complete a living will. You can also write your wishes down and/or discuss them with your physician or other health care provider and ask him or her to write it down in your chart. You might also want to use written or on-line resources to guide you through this process.

WHAT DO I DO WITH THIS FORM ONCE I COMPLETE IT?

Follow these instructions after you have completed the form:

(i) Sign the form in front of a witness. See the form for a list of who can and cannot witness it.

(ii) Ask the witness to sign it, too.

(iii) There is no need to have the form notarized.

(iv) Give a copy to your agent and to each of your successor agents.

(v) Give another copy to your physician.

(vi) Take a copy with you when you go to the hospital.

(vii) Show it to your family and friends and others who care for you.

WHAT IF I CHANGE MY MIND?

You may change your mind at any time. If you do, tell someone who is at least 18 years old that you have changed your mind, and/or destroy your document and any copies. If you wish, fill out a new form and make sure everyone you gave the old form to has a copy of the new one, including, but not limited to, your agents and your physicians.

WHAT IF I DO NOT WANT TO USE THIS FORM?

In the event you do not want to use the Illinois statutory form provided here, any document you complete must be executed by you, designate an agent who is over 18 years of age and not prohibited from serving as your agent, and state the agent's powers, but it need not be witnessed or conform in any other respect to the statutory health care power.

If you have questions about the use of any form, you may want to consult your physician, other health care provider, and/or an attorney.

Living Will

DECLARATION

This declaration is made this _____ day of_____(month, year).

I, _____, being of sound mind, willfully and voluntarily make known my desires that my moment of death shall not be artificially postponed.

If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such death delaying procedures, it is my intention that this declaration shall be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Signed_____

City, County and State of Residence_____

The declarant is personally known to me and I believe him or her to be of sound mind. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he or she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant's signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.

Witness_____

Witness_____

State of Illinois
Illinois Department of Public Health

Illinois Statutory Short Form
Power of Attorney for Health Care

MY POWER OF ATTORNEY FOR HEALTH CARE

THIS POWER OF ATTORNEY REVOKES ALL PREVIOUS POWERS OF ATTORNEY FOR HEALTH CARE

My name (Print your full name): _____

My address: _____

I WANT THE FOLLOWING PERSON TO BE MY HEALTH CARE AGENT (an agent is your personal representative under state and federal law):

(Agent name) _____

(Agent address) _____

(Agent phone number) _____

Please check box if applicable:

☐ If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as guardian.

MY AGENT CAN MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING:

(i) Deciding to accept, withdraw, or decline treatment for any physical or mental condition of mine, including life-and-death decisions.

(ii) Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.

(iii) Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.

(iv) Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue, or whole body donation, autopsy, cremation, and burial.

I AUTHORIZE MY AGENT TO: (Please check only one box. If no box is checked, or if more than one box is checked, the directive in the first box below shall be implemented.)

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.

☐ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability. Starting now, for the purpose of assisting me with my health care plans and decisions, my agent shall have complete access to my medical and mental health records, the authority to share them with others as needed, and the complete ability to communicate with my personal physician(s) and other health care providers, including the ability to require an opinion of my physician as to whether I lack the ability to make decisions for myself.

☐ Make decisions for me starting now and continuing after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

LIFE-SUSTAINING TREATMENTS:

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes. Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements. SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES **(optional)**:

☐ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.

☐ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically on the lines below or add another page if needed:

_____

_____

_____

_____

YOU MUST SIGN THIS FORM AND A WITNESS MUST ALSO SIGN IT BEFORE IT IS VALID.

My signature: _____ Today's date: _____

HAVE YOUR WITNESS AGREE TO WHAT IS WRITTEN BELOW, AND THEN COMPLETE THE SIGNATURE PORTION:

I am at least 18 years old. (Check one of the options below.)

☐ I saw the principal sign this document, or

☐ the principal told me that the signature or mark on the principal signature line is his or hers.

I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent, or the successor agent(s) by blood, marriage, or adoption. I am not the principal's physician, advanced practice registered nurse, dentist, podiatric physician, optometrist, psychologist, or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the health care facility where the principal is a patient or resident.

Witness printed name: _____

Witness address: _____

Witness signature: _____ Today's date: _____

SUCCESSOR HEALTH CARE AGENT(S) (optional):

If the agent I selected is unable or does not want to make health care decisions for me, then I request the person(s) I name below to be my successor health care agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names).

_____

(Successor agent #1 name, address and phone number)

_____

(Successor agent #2 name, address and phone number)

State of Illinois
Department of Public Health

IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients: Use of this form is completely voluntary. If desired, have someone you trust with you when discussing a POLST form with a health care professional. For health care providers: Complete this form only after a conversation with the patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. With significant change in condition, new orders may need to be written.

PATIENT INFORMATION. *For patients: Use of this form is completely voluntary.*

Patient Last Name	Patient First Name	MI

Date of Birth (mm/dd/yyyy)	Address (street/city/state/ZIP code)

A *Required to Select One*

ORDERS FOR PATIENT IN CARDIAC ARREST. Follow if patient has NO pulse.

☐ YES CPR: Attempt cardiopulmonary resuscitation (CPR). Utilize all indicated modalities per standard medical protocol. (Requires choosing Full Treatment in Section B.)	☐ NO CPR: Do Not Attempt Resuscitation (DNAR).

B *Section may be Left Blank*

ORDERS FOR PATIENT NOT IN CARDIAC ARREST. Follow if patient has a pulse. Maximizing comfort is a goal regardless of which treatment option is selected. (When no option selected, follow Full Treatment.)

☐ **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments.** Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.

☐ **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.

☐ **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death.** Use medication by any route as needed. Use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

C *Section may be Left Blank*

Additional Orders or Instructions. These orders are in addition to those above (e.g., withhold blood products; no dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]

D *Section may be Left Blank*

ORDERS FOR MEDICALLY ADMINISTERED NUTRITION. Offer food by mouth if tolerated. (When no selection made, provide standard of care.)

☐ Provide artificial nutrition and hydration by any means, including new or existing surgically-placed tubes.

☐ Trial period for artificial nutrition and hydration but NO surgically-placed tubes.

☐ No artificial nutrition or hydration desired.

E *Required*

Signature of Patient or Legal Representative. *(eSigned documents are valid.)*

X Printed Name ***(required)***	Date

Signature ***(required)*** *I have discussed treatment options and goals for care with a health care professional. If signing as legal representative, to the best of my knowledge and belief, the treatments selected are consistent with the patient's preferences.*

X

Relationship of Signee to Patient: ☐ Patient ☐ Parent of minor	☐ Agent under Power of Attorney for Health Care	☐ Health care surrogate decision maker (See Page 2 for priority list)

F *Required*

Qualified Health Care Practitioner. Physician, licensed resident (second year or higher), advanced practice nurse, or physician assistant. (eSigned documents are valid.)

X Printed Authorized Practitioner Name ***(required)***	Phone

Signature of Authorized Practitioner ***(required)*** *To the best of my knowledge and belief, these orders are consistent with the patient's medical condition and preferences.* X	Date ***(required)***

****THIS PAGE IS OPTIONAL – use for informational purposes****		
Patient Last Name	Patient First Name	MI

Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records a patient's wishes for medical treatment in their current state of health. The patient or patient representative and a health care provider should reassess and discuss interventions regularly to ensure treatments are meeting patient's care goals. This form can be changed to reflect new wishes at any time.
No form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows a person to document, in detail, future health care instructions and name a Legal Representative to speak on their behalf if they are unable to speak for themselves.

Advance Directives available for patient at time of this form completion			
☐ Power of Attorney for Health Care	☐ Living Will Declaration	☐ Declaration for Mental Health Treatment	☐ None Available

Health Care Professional Information	
Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH POLST Form

- The completion of a POLST form is always voluntary, cannot be mandated, and may be changed at any time.
- A POLST should reflect current preferences of persons completing the POLST Form; encourage completion of a POAHC.
- Verbal/phone consent by the patient or legal representative are acceptable.
- Verbal/phone orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of the original form is encouraged. Digital copies and photocopies, including faxes, on ANY COLOR paper are legal and valid.
- Forms with eSignatures are legal and valid.
- A qualified health care practitioner may be licensed in Illinois or the state where the patient is being treated.

Reviewing a POLST Form

This POLST form should be reviewed periodically and in light of the patient's ongoing needs and desires. These include:

- transfers from one care setting or care level to another;
- changes in the patient's health status or use of implantable devices (e.g., ICDs/cerebral stimulators);
- the patient's ongoing treatment and preferences; and
- a change in the patient's primary care professional.

Voiding or revoking a POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying, or revising a POLST form requires completion of a new POLST form.
- Draw line through sections A through E and write "VOID" across page if any POLST form is replaced or becomes invalid.
- Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult children
4. Parents
5. Adult siblings
6. Adult grandchildren
7. A close friend of the patient
8. The patient's guardian of the estate
9. The patient's temporary custodian appointed under subsection (2) of Section 2-10 of the Juvenile Court Act of 1987 if the court has entered an order granting such authority pursuant to subsection (12) of Section 2-10 of the Juvenile Court Act of 1987.

For more information, visit the IDPH Statement of Illinois law at http://dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/advance-directives

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996)
PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

CHECK REQUEST

Fairfield Memorial Hospital
303 NW 11th Street
Fairfield, IL 62837

☼ ☼

Requested By: _____ Date: _____

Payable to: Name _____

Attn. _____

Address _____

City _____ State _____ Zip _____

Amount Requested: _____ Charge Account: _____

Reason _____

_____

_____

_____

- ☐ Mail Directly to Payee
- ☐ Mail with Attachment to Payee
- ☐ Give Check to Requestor
- ☐ Will need a copy of the Tax Exemption Certificate Sent with the Check
- ☐ Other _____

_____
Approved

_____
CFO, CNO, COO, or CEO Approval

FMH-MISC-7 (11-18) (w)