Snug

Health Care Directive

A Health Care Directive is a legal document that specifies your medical care preferences and designates someone to make health care decisions on your behalf if you're unable to.

Common uses for a Health Care Directive include:

1. **Health Care Proxy:** Appoint a spouse or trusted individual to make medical decisions on your behalf if you ever become incapacitated.
2. **End-of-Life Care:** Specify in your Health Care Directive your wishes to receive life-prolonging treatments, such as resuscitation or artificial ventilation.
3. **Specific Medical Preferences:** Include specific instructions about medications to avoid and preferred alternatives, ensuring your safety.

COLORADO DURABLE POWER OF ATTORNEY FOR HEALTH CARE

(Colorado Revised Statutes 15-14-506)

THIS IS AN IMPORTANT LEGAL DOCUMENT. BEFORE SIGNING THIS DOCUMENT YOU SHOULD REVIEW AND UNDERSTAND THE DOCUMENT.

Your Colorado Advance Medical Directive is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

You may also want to save a copy of your form in an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

Remember, you can always revoke your Colorado document.

Be aware that your document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called “prehospital medical care directives” or “do not resuscitate orders” are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

MEDICAL DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS

1. DESIGNATION OF AGENT.

Appointment of Initial Agent. I, John Smith, Declarant, residing at 3010 East Mexico Avenue, Denver, CO, USA, hereby appoint:
Name: Jane Smith
Address:
Phone:

as my Agent (my 'Agent') to make health care decisions for me if and when I am unable to make my own health care decisions. This gives my agent the power to consent to giving, withholding or stopping any health care, treatment, service, or diagnostic procedure. My agent also has the authority to talk with health care personnel about my condition, access my medical records, get information and sign forms necessary to carry out those decisions.

If the person named as my agent is not available or is unable or unwilling to act as my agent, then I appoint the following person(s) to serve in the order listed below:
Name: Jill Smith
Address:
Phone:

Name: Bill Smith
Address:
Phone:

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE.

By this document I intend to create a Medical Durable Power of Attorney which shall take effect upon my incapacity to make my own health care decisions and shall continue during that capacity.

3. GENERAL STATEMENT OF AUTHORITY GRANTED.

Subject to any limitations in this document, I hereby grant to my Agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my Agent shall make health care decisions that are consistent with my desires as stated in this document

or otherwise made known to my Agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life- prolonging care, treatment, services, and procedures.

(If you want to limit the authority of your Agent to make health care decisions for you, you can state the limitations in paragraph D ('Statement of Desires, Special Provisions, and Limitations') below. You can indicate your desires by including a statement of your desires in the same paragraph.)

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS.

(Your Agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your health care. You can also make your desires known to your agent by discussing your desires with your Agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your Agent by this document, you should state the limits in the space below. If you do not state any limits, your Agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for health care, my Agent shall act consistently with my desires as stated. Additional statement of desires, special provisions, and limitations:

Special Desires:

_____
_____
_____
_____

Limitations on Agents:

_____
_____

_____
_____

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign each of the additional pages at the same time you date and sign this document.)

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH.

Subject to any limitations in this document, my Agent has the power and authority to do all of the following:

1. Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.
2. Execute on my behalf any releases or other documents that may be required in order to obtain this information.
3. Consent to the disclosure of this information.
4. Consent to the donation of any of my organs for medical purposes.

(If you want to limit the authority of your Agent to receive and disclose information relating to your health, you must state the limitations in paragraph D ('Statement of Desires, Special Provisions, and Limitations') above.)

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES.

Where necessary to implement the health care decisions that my agent is authorized by this document to make, my Agent has the power and authority to execute on my behalf all of the following:

1. Documents titled or purporting to be a 'Refusal to Permit Treatment' and 'Leaving Hospital Against Medical Advice.'
2. Any necessary waiver or release from liability required by a hospital or physician.
3. Signature of person creating medical durable power of attorney.

7. PRIOR DESIGNATIONS REVOKED.

I revoke any prior durable power of attorney for health care.

By signing here, I indicate that I understand the purpose and effect of this document. Signed this _____ day of_____, 20_____.

_____
John Smith, Principal

_____
Date

STATE OF COLORADO
COUNTY OF _____

SUBSCRIBED and sworn before me by John Smith, the declarant, as the voluntary act and deed of the declarant on this _____ day of_____, 20_____.

(SEAL)

_____
Notary Public: State of Colorado

_____
My commission expires

ADVANCE DIRECTIVE FOR MEDICAL/SURGICAL TREATMENT (Living Will)

1. DECLARATION

I, John Smith, residing at 3010 East Mexico Avenue, Denver, CO, USA, am at least eighteen (18) years of age 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 (2) qualified physicians to have a Terminal Condition or be in a Persistent Vegetative State (as those terms are defined under Colorado law):

Terminal Condition.

If at any time my attending 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)

[ ] 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.
[ ] I direct that life-sustaining procedures share 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)

[ ] Artificial nutrition and hydration shall not be continued.
[ ] Artificial nutrition and hydration shall be continued for/until:

(state timeframe or goal).

_____
_____

[ ] Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

Persistent Vegetative State.

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

1. Life-Sustaining Procedures

(initial one)

[ ] 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.
[ ] I direct that life-sustaining procedures share 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)

[ ] Artificial nutrition and hydration shall not be continued.
[ ] Artificial nutrition and hydration shall be continued for/until:

(state timeframe or goal).

_____
_____
[ ] Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

2. OTHER DIRECTIONS

Please indicate below if you have attached to this form any other instructions for your care after you are certified to have a Terminal Condition or are in a Persistent Vegetative State (for instance, to be enrolled in a hospice program, remain at or be transferred to home, discontinue or refuse other treatments, such as dialysis, transfusions, antibiotics, diagnostic tests, etc.):

[ ] Yes, I have attached other directions.
[ ] No, I have not attached other directions.

3. RESOLUTION WITH MEDICAL POWER OF ATTORNEY

4. 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 Healthcare Agents under a Medical Durable Power of Attorney.

(Include Name, Relationship, and Phone Number)

_____
_____
_____
_____

5. ANATOMICAL GIFTS

(initial one)

[ ] I wish to donate my organs and/or tissues, if medically possible.
[ ] I do not wish to donate my organs or tissues.

I execute this declaration as my free and voluntary act on this _____ day of _____, 20_____ and that this declaration has been witnessed and acknowledged in accordance with Colorado Revised Statutes Sections 15-19-205(b)(1) and 15-18-106.

_____
John Smith, Principal

_____
Date

STATE OF COLORADO
COUNTY OF _____

SUBSCRIBED and sworn before me by John Smith, the declarant, as the voluntary act and deed of the declarant on this _____ day of_____, 20_____.

(SEAL)

_____
Notary Public: State of Colorado

_____
My commission expires