Advance Directives in Arizona

What are Advance Directives?

Advance directives are your oral and/or written instructions about your future medical care. Advance directive documents include:

- Living Will
- Health Care Power of Attorney
- Pre-Hospital Directives

What is a living will?

A living will is a document where you put your wishes in writing about medical treatment in case you are unable to orally communicate them. Your right to accept or refuse treatment is protected by constitutional and common law.

What is a medical power of attorney?

A medical power of attorney is a document that enables you to appoint someone you trust to make decisions about your medical care if you are unable to make those decisions yourself. The person you appoint may be called your health care agent, surrogate, health care power of attorney, attorney-in-fact or proxy. This person acts as your agent and helps to ensure that your medical wishes are considered or followed.

What is a pre-hospital directive?

A pre-hospital directive is a legal document that is used to refuse care in an emergency situation. It is intended for those who wish not to receive emergency medical services, such as chest compressions, defibrillation, assisted ventilation, intubation or advanced life support medication. Emergency medical personnel or hospital personnel must withhold care to those persons who are identified as having valid directives. (Note: original intent was for terminally ill patients.)

Why do I need an advance directive?

Advance directives provide you with the opportunity to voice your decisions about your medical care when you are unconscious or unable to communicate. Every person has a right to self-determination in the provision of medical care.

Each of you has the right to refuse care as long as you are able to express your own decisions. Your advance directives should not be used as long as you are able to communicate. But if you become seriously ill and unable to communicate, you may lose the ability to participate in decisions about your own treatment.

What statutes govern the use of health care advance directives?

Both federal and state laws govern the use of advance directives. The federal law, the Patient Self-Determination Act, requires health care facilities that receive Medicaid and Medicare funds to inform patients of their rights to execute advance directives. All 50 states and the District of Columbia have laws recognizing the use of advance directives.

For more information on Advance Directives, contact:

Arizona Department of Economic Security
Aging & Adult Administration
1789 West Jefferson 2SW (950-A)
Phoenix, AZ 85007
602-542-4446, FAX 602-542-6575

17022-3/01

Health Care Directive

(Combined Living Will and Health Care Power of Attorney)

I, _____, currently reside in _____, Arizona, and execute this Health Care Directive in accordance with Title 36, Chapter 32, Arizona Revised Statutes. I want this directive to be in effect anytime two physicians, one of whom is my attending physician, personally examine me and certify that I am incapable of making or communicating my health care decisions.

This Health Care Directive is intended to be valid in any jurisdiction in which it is presented. The powers delegated under this directive are separable, so that the invalidity or revocation of one or more powers shall not affect any others. This directive shall not be affected or revoked by my disability.

I hereby authorize that photocopies of this directive can be relied upon as though they were originals. This directive continues in effect for all who may rely on it except those to whom I have given notice of its revocation. I understand that I can revoke a specific part, or all, of this directive by any oral or written statement to that effect, or by any other expression of intention to revoke all or a specific part.

If a Guardian is to be appointed for me, I nominate my agent (or alternate) named below. If a court decides to appoint someone else, I ask that the court require the guardian to consult with these people concerning all health care decisions that would require my consent if I were acting for myself.

I. Health Care Power of Attorney

I appoint:

Name: _____

Address: _____

Phone Number(s): (Home)(____)_____ (Work)(____)_____
as my agent for all matters relating to my health care. This Health Care Power of Attorney is to remain in effect after my death for my agent to make decisions regarding autopsy, organ or tissue donation, or disposition of my remains, if I authorize those below.

Initials:_____

Initials:_____

Initials:_____

A. Powers. My agent should try to discuss specific decisions with me if I am able to communicate in any manner. If I am unconscious, comatose, senile or otherwise unable to communicate, my agent may do whatever he or she deems necessary to effectuate the terms of this Health Care Directive, including, but not limited to the powers listed below:

Employ and discharge medical, social service and other support personnel responsible for my care.

Contract on my behalf for any health care related service or facility for my care, without my agent incurring personal financial liability for such contracts.

Grant any waiver or release from liability required by any hospital, physician or other health care provider.

Have access to medical records and information to the same extent I am entitled to.

Release my medical information to third parties, including, but not limited to, hospitals, medical clinics and insurance companies.

Give, withhold or withdraw consent to medical care, treatment, surgical procedures, diagnostic procedures, medication, hospital and related health care or treatment.

Refuse, consent to, or withdraw consent to life-sustaining procedures(s) as authorized in this directive.

Summon emergency medical personnel and seek emergency treatment for me, or choose not to do so, as my agent may deem appropriate given my preferences regarding such care that are expressed in this directive, and my medical status at the time of the decision.

Pursue any legal action in my name, at the expense of my estate, to force compliance of my wishes as determined by my agent, or to seek actual or punitive damages for the failure to comply.

All of my agent's actions under this power during any period when I am unable to make or communicate health care decisions or when there is uncertainty whether I am dead or alive have the same effect on my heirs, devisees and personal representatives as if I were alive, competent and acting for myself.

Initials:_____

Initials:_____

Initials:_____

B. Reimbursement. My agent shall be entitled to reimbursement for all reasonable expenses incurred as a result of carrying out any provision of this directive.

_____ My agent shall be entitled to compensation for services performed under this Health Care Power of Attorney.

_____ My agent shall not be entitled to compensation for services performed under this Health Care Power of Attorney.

C. Alternate Agents. If _____ is unavailable or is unable to act as my agent, I appoint the following persons to serve as my agent to make health care decisions as authorized in this directive, such persons to serve in the order listed below:

First Alternate:

Name: _____

Address: _____

Phone Number(s): (Home)(___)_____ (Work)(____)_____

Second Alternate:

Name: _____

Address: _____

Phone Number(s): (Home)(___)_____ (Work)(____)_____

If an alternate acts for me because the first agent is unavailable, I intend that the alternate act only while my first agent is unavailable.

D. Removal of Agent. If my spouse has been appointed my agent or an alternate agent and, subsequent to the execution of this directive an action is filed to dissolve our marriage, then the filing of such action shall automatically remove my spouse as agent or alternate agent.

Initials:_____

Initials:_____

Initials:_____

E. Decisions Regarding My Body After My Death. I choose the following, indicated by my initials:

_____ I do not consent to an autopsy.

_____ I consent to an autopsy.

_____ My agent may give consent to or refuse an autopsy.

_____ I do not want to make an organ or tissue donation and I do not want my agent or family to do so.

_____ I hereby give, effective on my death:

_____ Any needed organ or part.

_____ The following part or organs listed: _____ for:

_____ Research, medical education or any other legally authorized purpose.

_____ Transplant purposes.

_____ I authorize my agent to dispose of my remains and make funeral arrangements.

_____ I do not want my body cremated.

F. Living Will Option. If I execute the Living Will portion of this Health Care Directive, I intend the initialed provisions below as supplemental guidelines for my agent to make decisions in situations that may occur during any period when I am unable to make or communicate health care decisions.

_____ I have completed the Living Will portion of this Health Care Directive by initialing certain statements to provide specific directions to assist my agent in making decisions.

_____ I have not completed the Living Will portion of this Health Care Directive.

II. Living Will

A. Clear and Convincing Evidence. It is my intention that this directive constitute clear and convincing evidence of my wishes concerning medical treatment if I am unable to make or communicate my own health care decisions at that time. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this directive be honored by my family and attending physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of such refusal.

B. Personal Value Statement. I value life, but the quality of my life is very important to me. I particularly want to avoid the conditions I have initialed below in Section II.E. of this directive. I do not want others to substitute their choices for mine or my health care agent's. If what I would want is not known, then decisions about my health care are to be made in my best interest, based on the contents of this directive and medical information provided by my physicians.

C. Temporary Use of Life-Sustaining Treatment. Notwithstanding any other directions, I do want the use of all medical care necessary to treat my condition until my physicians reasonably conclude that I have one or more of the conditions initialed in Section II.E.1 on the following page.

_____ If I experience any of the conditions initialed in Section II.E.1, but my physicians believe that temporary use of life-sustaining treatment would probably restore acceptable quality of life:

_____ I want life-sustaining treatment for up to _____ days/weeks/months.

_____ I still do not want life-sustaining treatment.

D. Pregnancy. Notwithstanding my other directions, if I am known to be pregnant:

_____ I do not want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

_____ I do want my Health Care Directive to remain in effect.

Initials:_____

Initials:_____

Initials:_____

E. Determination of Condition. If two physicians agree that I am unable to make or communicate health care decisions, and I have one or more of the conditions I have initialed in Section II.E.1 below, I want my medical care to be controlled by the statements I have initialed in Section II.E.2 below, regarding preferred health care treatment:

1. Conditions.

_____ Life-threatening condition; or

_____ Irreversible coma or a persistent vegetative state from which ability to think and communicate probably will not be recovered; or

_____ Unconsciousness lasting ___ days/weeks/months; or

_____ Loss of the ability to think or communicate effectively caused by brain disease or brain damage that probably is not reversible; or

_____ Total dependence on others for my care, because of physical or mental deterioration that probably is not reversible; or

_____ Senile dementia such that I cannot live independently or recognize family members or friends; or

_____ Severe pain that will probably never be eliminated; or

_____ Pain that can be eliminated only by so much pain medication that ability to communicate verbally is lost.

_____ Other circumstances in which I do not want life-sustaining treatment include:

_____

_____

_____

2. Treatment.

_____ PROVIDE FULL COMFORT CARE, including supplemental oxygen (mask or nasal canula), pain medication and sedation, even though their use may lead to permanent physical damage, cause addiction or even hasten the moment of my death.

_____ DO NOT RESUSCITATE: No chest compressions; no cardiac shock; no artificial ventilation (no positive pressure mask or bag ventilation, no endotracheal tube, no mechanical ventilation); no cardiovascular medication.

Initials:_____

Initials:_____

Initials:_____

_____ DO PERFORM FULL, UNLIMITED RESUSCITATION AND TREATMENT.

_____ DO PERFORM PARTIAL RESUSCITATION to determine if I respond positively.

_____ No chest compressions

_____ No cardiac shock

_____ No artificial ventilation (no positive pressure mask or bag ventilation, no endotracheal tube, no mechanical ventilation)

_____ No cardiovascular medication

_____ Other_____

_____ DO NOT ARTIFICIALLY ADMINISTER FOOD AND FLUIDS if they would only serve to prolong artificially the moment of my death, even though I may then die from malnutrition or dehydration rather than from my injury, disease, illness or condition.

_____ DO NOT WITHHOLD ARTIFICIALLY ADMINISTERED FOOD AND LIQUIDS if I would die from malnutrition or dehydration rather than from my injury, disease, illness or condition.

_____ PROLONG MY LIFE TO THE GREATEST EXTENT POSSIBLE.

_____ DO NOT PROLONG MY LIFE by providing life-sustaining or death-delaying treatment, including artificially administered food and nutrition, if the burdens of the treatment outweigh the expected benefits. My agent is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.

_____ DO NOT PERFORM:

- _____ Minor surgery
- _____ Major surgery
- _____ Invasive diagnostic tests, such as cardiac catheterization
- _____ Transfusion of blood or blood products

_____ DO NOT ADMINISTER:

- _____ Antibiotic treatment
- _____ Insulin
- _____ Chemotherapy
- _____ Kidney dialysis

_____ DO NOT TAKE ME TO A HOSPITAL IF AT ALL AVOIDABLE.

Initials:_____

Initials:_____

Initials:_____

The treatments that my agent may give, withhold or withdraw consent to is not limited to those items listed above, but is a general reference to the types of treatment I, if capable, would either request or refuse.

I, _____, the Principal, sign my name to this Health Care Directive and hereby declare that I understand the full import of this directive, that I have the emotional and mental capacity to execute this Health Care Directive, and that I signed and executed this directive as my free and voluntary act.

Signature _____

We, the below signed witnesses, sign our names to this Health Care Directive, being first duly sworn and hereby declare to the undersigned authority that the Principal signs and executes this directive willingly and each of us in the presence and hearing of the Principal sign as witness and each believes the Principal to be of sound mind, having fully understood the significance of this directive, and the Principal has the emotional and mental capacity to make this Health Care Directive. Each witness affirms that he or she: (1) is at least 18 years old; (2) is not related to the Principal by blood, marriage or adoption; (3) is not an agent named in this Health Care Directive; (4) is not directly involved in the Principal's health care; (5) is not, to his or her knowledge, a beneficiary of the Principal's will or any codicil; and (6) has no claim against the Principal's estate.

_____/_____

WITNESS RESIDING AT

_____/_____

WITNESS RESIDING AT

State of Arizona)

)ss:

County of _____)

SUBSCRIBED, SWORN TO AND ACKNOWLEDGED before me this date:

_____ by _____, and by the above named

witnesses _____ and _____

My Commission Expires: _____ _____

NOTARY PUBLIC