



# A Personal Decision

2016 EDITION

## Practical Information About Determining Your Future Medical Care

- Living wills
- Powers of attorney for health care
- Mental health treatment preference declarations
- Uniform POLST form
- Organ donation



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Society

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## A Personal Decision

YOU CAN DECIDE TODAY ABOUT THE  
MEDICAL CARE YOU WILL RECEIVE  
IN THE FUTURE

**W**hile advances in medicine and medical technology can save many lives that only 50 years ago might have been lost, the issue of quality at the end of life has come under intensive judicial and public scrutiny. In the state of Illinois, it is your legal right at all times to determine the degree and kind of care you wish to receive. This includes your right (as an adult) to consent to or refuse medical care and treatment as long as you are capable of doing so.

You can also decide today and direct your physician, health care team and family about the care you want in the event of an illness or injury, including terminal illness, if you are unable then to make these decisions. You can decide today whether you want procedures such as artificial breathing and kidney treatments, feeding through a tube or a vein, and others, if they would only prolong the process of dying and do no more than delay your death. You can also decide to refrain from care and allow a natural death.

Decisions about the quality of the end of life – about life support systems, aggressive resuscitation efforts, hydration and nutrition of comatose patients, and withholding or withdrawing life-sustaining treatment or care – are all serious, personal decisions each of us must arrive at privately. Neither the law nor any person can require you to make such a decision against your will. If you wish to exercise your right to determine the care you receive should you be injured or ill, this brochure will help you make an informed decision. ■

### How to Indicate Your Decisions

**I**n Illinois, four documents are available for your use in directing your health care when you are incapable of doing so: the Durable Power of Attorney for Health Care, the Declaration for Mental Health Treatment, the living will, and the Uniform POLST form. You can use any one or more of these documents, or you may write out your wishes and directives. The choice is yours, and you can change your mind at any time, except for the declaration under specified circumstances. ■

### Durable Power of Attorney for Health Care

**I**n the state of Illinois the best way to ensure that your instructions about your health care are followed is through the use of a Durable Power of Attorney for Health Care. Using this document you can designate someone else, called an “agent,” to make decisions about your health care in the event you are unable to do so yourself. This person can, by law, be anyone over the age of 18 you choose, except a physician or other health care professional providing you with care. This person will have the legal right and responsibility to make decisions about your health care, including the initiation and termination of medical procedures and life support systems, organ donation and autopsy.

For example, a person with irreversible brain injuries remains in a coma from which physicians have determined the patient will never recover. The agent designated in the durable power of attorney for health care can refuse the treatment that the hospital would administer should the patient develop pneumonia. Without the treatment, the pneumonia would most likely be fatal. Because the patient has determined – in advance, through discussion with their agent and by signing the durable power of attorney – that death should not be delayed in this circumstance, the agent is authorized to decline lifesaving efforts.

Most people select a member of their family or a close friend to act as their agent in these situations. You may designate several agents, in case your first choice of a decision-maker is unavailable or unwilling to serve – however, only one person can be your agent at any time. Whomever you choose, you should discuss your wishes with them.

While your caregivers must respect your agent’s decisions and the court will uphold them, the agent can be removed by the court if doing so is determined to be in your best interest. Your physician and the hospital will also play a part in that decision.

The Durable Power of Attorney for Health Care form in this brochure is legal in the state of Illinois. This form is not required, but it is the surest way to meet all the specifications of Illinois law. If you decide to execute the durable power of attorney, be sure to

inform your physician, the hospital and your family. If possible, you should provide a copy to your physician, hospital or nursing home. Keep the form in a safe place and let someone you trust know where it is. ■

### The Living Will

**T**he living will does not appoint another person to make your health care decisions, but declares your intent that, if your medical condition is incurable and irreversible and your death is imminent, the people taking care of you should not delay your death through death-delaying measures. It allows you to control your health care even if you cannot communicate with the people caring for you.

For example, a cancer patient whom the physicians estimate has only weeks to live can, through the use of a living will, instruct the hospital that no extraordinary measures are to be taken to prolong her life; if she suffers cardiac arrest, for example, the hospital is not to attempt to revive her. She may also choose to decline the future use of a respirator or techniques such as blood transfusions or kidney dialysis.

Any adult (over the age of 18) of sound mind can make a living will. The living will must be created voluntarily, signed by the patient (or another person at the direction of the patient), and witnessed by two adults. The living will has no legal effect unless the physician responsible for the patient's care certifies, in writing, that the patient's condition is terminal, that death is imminent, and that death-delaying procedures will only prolong the process of dying. Nutrition and hydration may not be withheld or withdrawn if such act (and not the existing medical condition) will cause death. The living will form in this brochure is legal in the state of Illinois; you may also include other directions and instructions. ■

### Uniform POLST Form

**T**he POLST form, similar to the living will form, does not appoint another person to make your health care decisions, but declares your intent that if you cannot make decisions yourself, you do not want cardiopulmonary resuscitation to be performed when your heartbeat and/or breathing stop. In addition, you may choose other medical interventions or artificial nutrition options. The Uniform POLST form must be

created voluntarily; be signed by the patient (or another person at the direction of the patient or a surrogate decision-maker) and the patient's attending physician, advanced practice nurse, physician assistant or medical resident (second year or higher); and be witnessed by one adult. The Uniform POLST form in this brochure has been developed by the Illinois Department of Public Health. It is also known as a Practitioner Orders for Life-Sustaining Treatment (POLST) form. ■

### Life Sustaining Treatment Withholding or Withdrawing Care

**B**y the use of any one of the three advance directive documents mentioned thus far, your decision or wishes with respect to receiving or withdrawing life-sustaining treatment can be preserved and carried out. Remember, you have the right to make these decisions. In fact, Illinois law states:

**All persons have the fundamental right to make decisions relating to their own medical treatment, including the right to forgo life-sustaining treatment.**

If you do not have one of these documents and lack decision-making capacity, then one of your relatives, a close friend or a court-appointed guardian may be chosen to act as your surrogate decision-maker. A surrogate must follow your expressed wishes, if known. (See surrogate discussion, p. 3). ■

### Declaration for Mental Health Treatment

**T**he Durable Power of Attorney allows your agent to also make decisions about your mental health; however, Illinois has a unique document, known as the Declaration for Mental Health Treatment, specifically limited to three types of mental health treatment.

Using this document you can designate someone else, called an attorney-in-fact, to make decisions about your mental health care in the event you are unable to do so yourself. This person can, by law, be anyone over the age of 18 you choose, except your attending physician and persons involved with or related to the physician or your health care facility. This person will have the legal right and responsibility to make limited decisions about your mental health care concerning: (1) electroconvulsive treatment, (2) psychotropic medication, and (3) admission for up to 17 days in a mental health facility.



Most people select a family member or a close friend to act as their attorney-in-fact in these situations. Whomever you choose, you should discuss your wishes with them. The Declaration for Mental Health Treatment form in this brochure is legal in the state of Illinois. This form is not required, but it is the surest way to meet all the specifications of Illinois law. If you decide to execute a Declaration for Mental Health Treatment, be sure to inform your physician, mental health care professional and your family. Keep the form in a safe place and let someone you trust know where it is. ■

### Changing Your Decision

**Y**ou can at any time amend, alter or void your living will, durable power of attorney or POLST form by destroying the document or preparing a written statement declaring your intent to revoke or cancel them. A Declaration for Mental Health Treatment may only be amended or revoked by you when you have decisional capacity and must be in writing, signed by you and your physician. The forms in this brochure allow you to direct your family, your health care professionals and the others involved in your medical care to follow your wishes should the time come when these difficult decisions must be made. You need not consult an attorney to put any of

these into effect; it is very important, however, that you discuss your decisions and these documents with your family, your physician and your legal advisor, to ensure that your wishes are followed. ■

### Without an Advance Directive, a Surrogate May be Chosen for You

**I**f you do not execute an advance directive and you lack decisional capacity, a surrogate decision-maker may be chosen for you. This may be a relative, a close friend, or a court-appointed guardian. This surrogate will have the authority to make medical treatment decisions for you. If your medical condition is terminal, incurable or irreversible, or you are permanently unconscious, your surrogate may also make life-sustaining treatment decisions for you.

A surrogate, other than a court-appointed guardian, may not consent to administration of electroconvulsive therapy or psychotropic medication or admission to a mental health facility without court approval. In other circumstances, your hospital, other health care institution or physicians may be required to do everything in their power to keep you alive, no matter what your condition or chances of recovery. ■



**Illinois Department of Public Health**  
**STATEMENT OF ILLINOIS LAW ON**  
**ADVANCE DIRECTIVES**

*The following statement was updated prior to the effective date of Public Act 99-319, which deleted “DNR” from the title of the “DNR/POLST” form. This statement was last accessed in Spring 2016.*

You have the right to make decisions about the health care you get now and in the future. An advance directive is a written statement you prepare that expresses how you want medical decisions made in the future should you not be able to make them yourself.

Federal law requires that you be told of your right to make an advance directive when you are admitted to a health care facility, and the Patient Self-Determination Act (see LAWS & RULES) requires certain providers participating in the Medicare and Medicaid programs to furnish patients with information on advance directives. The information is to be given to patients upon admission to a facility or when provision of care begins. Providers covered by this requirement include hospitals, nursing facilities, providers of home health or personal care services, hospice programs and health maintenance organizations.

Illinois law allows you to make four types of advance directives: a health care power of attorney; a living will; a mental health treatment preference declaration, and a Do-Not-Resuscitate (DNR)/Practitioner Orders For Life-Sustaining Treatment (POLST). The Department of Public Health is required by law (see Illinois Compiled Statutes – Advance Directive Information under LAWS & RULES) to make available to you standard forms for each of these types of advance directives. The forms can be downloaded at the following website. More information on these advance directives is provided below.

After reviewing the information below on the different types of advance directives, you may want to discuss them with your family, your health care professional and/or attorney. You may decide to make more than one advance directive. For example, you could make a health care power of attorney, as well as a living will. If you decide to have one or more

advance directives, you should tell your health care professionals and provide them with copies of any advance directives you have. You should also provide copies of your advance directives to those you have appointed to make health care decisions for you, and you may want to provide copies to your family members.

### **Health Care Power of Attorney**

The **health care power of attorney** lets you choose someone to make health care decisions for you in the future, if you are no longer able to make these decisions for yourself. You are called the “principal” in the power of attorney form and the person you choose to make decisions is called your “agent.” Your agent would make health care decisions for you if you were no longer able to make these decisions for yourself. So long as you are able to make these decisions, you will have the power to do so. You may give your agent specific directions about the health care you do or do not want. The agent you choose cannot be your health care professional or other health care provider. You should have someone who is not your agent witness your signing of the power of attorney.

The power of your agent to make health care decisions on your behalf is broad. Your agent would be required to follow any specific instructions you give regarding care you want provided or withheld. For example, you can say whether you want all life-sustaining treatments provided in all events; whether and when you want life-sustaining treatment ended; instructions regarding refusal of certain types of treatments on religious or other personal grounds; and instructions regarding anatomical gifts and disposal of remains. Unless you include time limits, the health care power of attorney will continue in effect from the time it is signed until your death. You can cancel your power of attorney at any time, either by telling someone or by canceling it in writing. You can name a backup agent to act if the first one cannot or will not take action. If you want to change your power of attorney, you must do so in writing.

You may use a standard health care power of attorney form or write your own.

## Living Will

A **living will** tells your health care professional whether you want death-delaying procedures used if you have a terminal condition and are unable to state your wishes. A living will, unlike a health care power of attorney, only applies if you have a terminal condition. A terminal condition means an incurable and irreversible condition such that death is imminent and the application of any death delaying procedures serves only to prolong the dying process.

Even if you sign a living will, food and water cannot be withdrawn if it would be the only cause of death. Also, if you are pregnant and your health care professional thinks you could have a live birth, your living will cannot go into effect.

You can use a standard living will form or write your own. You may write specific directions about the death-delaying procedures you do or do not want. Two people must witness your signing of the living will. Your health care professional cannot be a witness. It is your responsibility to tell your health care professional if you have a living will, if you are able to do so. You can cancel your living will at any time, either by telling someone or by canceling it in writing.

If you have both a health care power of attorney and a living will, the agent you name in your power of attorney will make your health care decisions unless he or she is unavailable.

## Mental Health Treatment Preference Declaration

A **mental health treatment preference declaration** lets you say if you want to receive electroconvulsive treatment (ECT) or psychotropic medicine when you have a mental illness and are unable to make these decisions for yourself. It also allows you to say whether you wish to be admitted to a mental health facility for up to 17 days of treatment.

You can write your wishes and/or choose someone to make your mental health decisions for you. In the declaration, you are called the “principal,” and the person you choose is called an “attorney-in-fact.” Neither your health care professional nor any employee of a health care facility in which you reside may be your attorney-in-fact. Your attorney-in-fact must accept the appointment in writing before he or

she can start making decisions regarding your mental health treatment. The attorney-in-fact must make decisions consistent with any desires you express in your declaration unless a court orders differently or an emergency threatens your life or health.

Your mental health treatment preference declaration expires three years from the date you sign it. Two people must witness you signing the declaration. The following people may not witness your signing of the declaration: your health care professional; an employee of a health care facility in which you reside; or a family member related by blood, marriage or adoption. You may cancel your declaration in writing prior to its expiration as long as you are not receiving mental health treatment at the time of cancellation. If you are receiving mental health treatment, your declaration will not expire and you may not cancel it until the treatment is successfully completed.

## Do-Not-Resuscitate/Practitioner Orders For Life-Sustaining Treatment

You may also ask your health care professional about having a **do-not-resuscitate (DNR)/practitioner orders for life-sustaining treatment (POLST)** (DNR/POLST Order). A DNR/POLST Order is an advanced directive that says that cardiopulmonary resuscitation (CPR) cannot be used if your heart and/or breathing stops; it can also be used to record your desires for life-sustaining treatment. The Department of Public Health has published a Uniform DNR/POLST Order that is available for download at this webpage. This webpage also provides a link to guidance for individuals, health care professionals and health care providers concerning the IDPH Uniform DNR/POLST Order.

The Uniform DNR/POLST Order requires your signature or that of your authorized legal representative (your legal guardian, health care power of attorney, or health care surrogate), as well as the signature of your attending practitioner and a witness who is 18 years of age or older. A DNR/POLST Order will not be entered into your medical record unless it contains all of the required signatures. You can ask your practitioner to work with you to prepare the Uniform DNR/POLST Order.

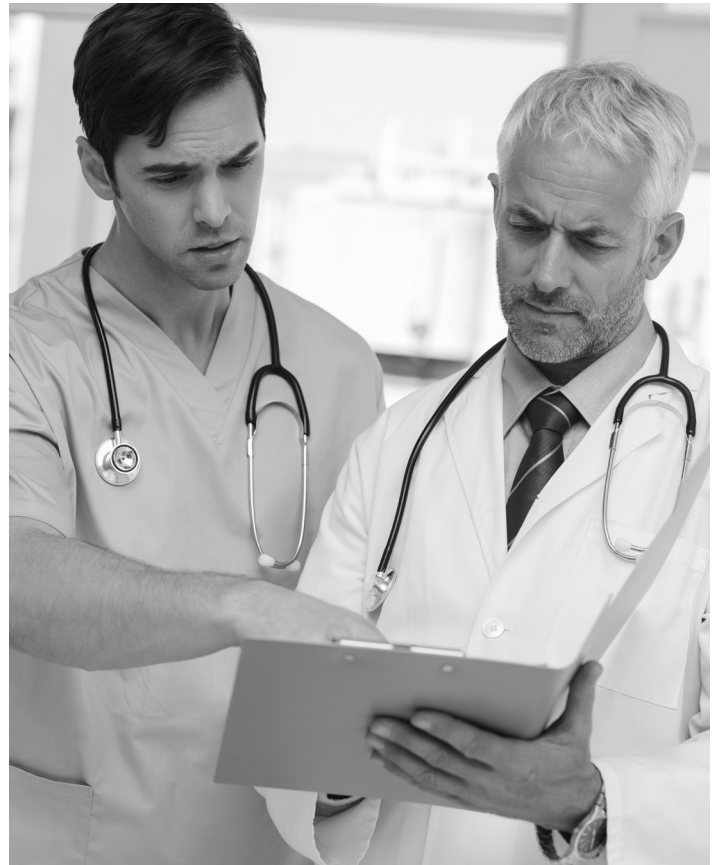


## What Happens If You Cannot Make Health Care Decisions For Yourself And You Don't Have an Advance Directive?

If you cannot make health care decisions for yourself, a health care “surrogate” may be chosen for you. Under Illinois law, two doctors must certify that you cannot make health care decisions for yourself before a health care surrogate can be appointed. A health care surrogate can be one of the following persons (in order of priority): guardian of the person, spouse, any adult child(ren), either parent, any adult brother or sister, any adult grandchild(ren), a close friend, or guardian of the estate.

However, while your health care surrogate can make most health care decisions for you, there are certain decisions that a surrogate cannot make. For example, a health care surrogate cannot tell your health care professional to withdraw or withhold life-sustaining treatment unless you have a “qualifying condition.” A qualifying condition can be (1) a “terminal condition” (an incurable or irreversible injury for which there is no reasonable prospect of cure or recovery, death is imminent, and life-sustaining treatment will only prolong the dying process); (2) “permanent unconsciousness” (a condition that, to a high degree of medical certainty, will last permanently, without improvement; there is no thought, purposeful social interaction or sensory awareness present; and providing life-sustaining treatment will only have minimal medical benefit), or (3) an “incurable or irreversible condition” (an illness or injury for which there is no reasonable prospect for cure or recovery, that ultimately will cause the patient’s death, that imposes severe pain or an inhumane burden on the patient, and for which life-sustaining treatment will have minimal medical benefit). Two doctors must certify that you have one of these qualifying conditions.

There are also limitations on the decision-making authority of a health care surrogate that relate to mental health treatment. A health care surrogate, other than a court-appointed guardian, cannot consent for you to have certain mental health treatments, including treatment by electroconvulsive therapy (ECT), psychotropic medication or admission to a mental health facility, although the health care surrogate can petition a court to allow these mental health services. To avoid the decision-making limitations of a health



care surrogate, you may want to consider having one or more advance directives.

### Final Notes

You should talk with your family, your health care professional, your attorney, and any agent or attorney-in-fact that you appoint about your decision to make one or more advance directives. If they know what health care you want, they will find it easier to follow your wishes. If you cancel or change an advance directive in the future, remember to tell these same people about the change or cancellation.

No health care facility, health care professional or insurer can make you execute an advance directive as a condition of providing treatment or insurance. It is entirely your decision. If a health care facility, health care professional or insurer objects to following your advance directive, they must tell you or the individual responsible for making your health care decisions. They must continue to provide care until you or your decision maker can transfer you to another health care provider who will follow the orders contained in your advance directive.





## The Living Will

The Living Will Act includes the following suggested form:

Declaration (as included in the Illinois Living Will Act, 755 ILCS 35/3)

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 interstate 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 \_\_\_\_\_

**(Comment:** *Even though the Act states that another form may be used, which may include specific prohibitions or types of procedures that may be acceptable, it is advisable that any variation from the form above should be subject to review by an attorney to assure its validity.*)



## **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 voice 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 advanced 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 make 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 you 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.



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

(You must sign this form and a witness must also sign it before it is valid)

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.

**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)

**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.

The above grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures.

**I AUTHORIZE MY AGENT TO** (please check any one box):

☐ 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.

(If no box is checked then the box above shall be implemented.) **OR**

☐ 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. **OR**



- ☐ 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.

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 in this form.

\_\_\_\_\_  
\_\_\_\_\_

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 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: \_\_\_\_\_

**DECLARATION FOR MENTAL HEALTH TREATMENT**

I, \_\_\_\_\_, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by two physicians or the court that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. "Mental health treatment" means electroconvulsive treatment, treatment of mental illness with psychotropic medication, and admission to and retention in a health care facility for a period up to 17 days.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

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**PSYCHOTROPIC MEDICATIONS** If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

\_\_\_\_\_ I consent to the administration of the following medications: \_\_\_\_\_

---

\_\_\_\_\_ I do not consent to the administration of the following medications: \_\_\_\_\_

---

Conditions or limitations: \_\_\_\_\_

**ELECTROCONVULSIVE TREATMENT**

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

\_\_\_\_\_ I consent to the administration of electroconvulsive treatment.

\_\_\_\_\_ I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations: \_\_\_\_\_

**ADMISSION TO AND RETENTION IN FACILITY**

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding admission to and retention in a health care facility for mental health treatment are as follows:

\_\_\_\_\_ I consent to being admitted to a health care facility for mental health treatment.

\_\_\_\_\_ I do not consent to being admitted to a health care facility for mental health treatment. This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.

Conditions or limitations: \_\_\_\_\_

**SELECTION OF PHYSICIAN** *(optional)*

If it becomes necessary to determine if I have become incapable of giving or withholding informed consent for mental health treatment, I choose Dr. \_\_\_\_\_ of \_\_\_\_\_ to be one of the two physicians who will determine whether I am incapable. If that physician is unavailable, that physician's designee shall determine whether I am incapable.

## ADDITIONAL REFERENCES OR INSTRUCTIONS

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Conditions or limitations: \_\_\_\_\_

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## ATTORNEY-IN-FACT

I hereby appoint:

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**TELEPHONE #:** \_\_\_\_\_

to act as my attorney-in-fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my attorney-in-fact, I authorize the following person to act as my attorney-in-fact:

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**TELEPHONE #:** \_\_\_\_\_

My attorney-in-fact is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my attorney-in-fact. If my wishes are not expressed and are not otherwise known by my attorney-in-fact, my attorney-in-fact is to act in what he or she believes to be my best interest.

\_\_\_\_\_  
(Signature of Principal/Date)

## AFFIRMATION OF WITNESSES

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this declaration for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is:

- A person appointed as an attorney-in-fact by this document;
- The principal's attending physician or mental health service provider or a relative of the physician or provider;
- The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident or;
- A person related to the principal by blood, marriage or adoption.

Witnessed By:

\_\_\_\_\_  
(Signature of Witness/Date)

\_\_\_\_\_  
(Signature of Witness/Date)

\_\_\_\_\_  
(Printed Name of Witness)

\_\_\_\_\_  
(Printed Name of Witness)



## ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT

I accept this appointment and agree to serve as attorney-in-fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental health treatment only while the principal is incapable as determined by a court or two physicians. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner when the principal is not incapable.

\_\_\_\_\_  
(Signature of Attorney-in-Fact/Date)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Signature of Attorney-in-Fact/Date)

\_\_\_\_\_  
(Printed Name)

## NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about three types of mental health treatment: psychotropic medication, electro-convulsive therapy, and short-term (up to 17 days) admission to a treatment facility. The instructions that you include in this declaration will be followed only if two physicians or the court believes that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

You may also appoint a person as your attorney-in-fact to make these treatment decisions for you if you become incapable. The person you appoint has a duty to act consistent with your desires as stated in this document or, if your desires are not stated or otherwise made known to the attorney-in-fact, to act in a manner consistent with what the person in good faith believes to be in your best interest. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your attorney-in-fact at any time.

This document will continue in effect for a period of three years unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

You have the right to revoke this document in whole or in part at any time you have been determined by a physician to be capable of giving or withholding informed consent for mental health treatment. A revocation is effective when it is communicated to your attending physician in writing and is signed by you and a physician. The revocation may be in a form similar to the following:

## REVOCATION

I, \_\_\_\_\_, willfully and voluntarily revoke my declaration for mental health treatment as indicated.

☐ I revoke my entire declaration.

☐ I revoke the following portion of my declaration: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_ Signed: \_\_\_\_\_  
(Signature of principal)

I, Dr. \_\_\_\_\_, have evaluated the principal and determined that he or she is capable of giving or withholding informed consent for mental health treatment.

Date: \_\_\_\_\_ Signed: \_\_\_\_\_  
(Signature of physician)

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.



State of Illinois  
Illinois Department of Public Health

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

**For patients, use of this form is completely voluntary.** Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	MI
Date of Birth (mm/dd/yy)		Gender <input type="checkbox"/> M <input type="checkbox"/> F
Address (street/city/state/ZIPcode)		

**A**

Check  
One

### CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

☐ **Attempt Resuscitation/CPR**

☐ **Do Not Attempt Resuscitation/DNR**

(Selecting CPR means Full Treatment in Section B is selected)

**When not in cardiopulmonary arrest, follow orders B and C.**

**B**

Check  
One  
(optional)

### MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.

- ☐ **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*
- ☐ **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*
- ☐ **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of 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. **Request transfer to hospital only if comfort needs cannot be met in current location.**

Optional Additional Orders \_\_\_\_\_

**C**

Check  
One  
(optional)

### MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired.

☐ Long-term medically administered nutrition, including feeding tubes.

**Additional Instructions (e.g., length of trial period)**

☐ Trial period of medically administered nutrition, including feeding tubes.

☐ No medically administered means of nutrition, including feeding tubes.

**D**

### DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

☐ Patient

☐ Agent under health care power of attorney

☐ Parent of minor

☐ Health care surrogate decision maker (See Page 2 for priority list)

#### Signature of Patient or Legal Representative

Signature (**required**)

Name (print)

Date

#### Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature (**required**)

Name (print)

Date

**E**

### Signature of Authorized Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Authorized Practitioner Name (**required**)

Phone

( ) -

Authorized Practitioner Signature (**required**)

Date (**required**)



Page 1

**\*\*THIS SIDE FOR INFORMATIONAL PURPOSES ONLY\*\***

Patient Last Name	Patient First Name	MI
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Use of the Illinois Department of Public Health (IDPH) Practitioner Orders for Life-Sustaining Treatment (POLST) Form is always voluntary. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, 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 you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

**Advance Directive Information****I also have the following advance directives (OPTIONAL)**

☐ Health Care Power of Attorney      ☐ Living Will Declaration      ☐ Mental Health Treatment Preference Declaration

Contact Person Name	Contact Phone Number
---------------------	----------------------

**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 orders are acceptable with follow-up signature by authorized practitioner in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

**Reviewing a POLST Form**

This POLST form should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another, or
- or there is a substantial change in the patient's health status, or
- or the patient's treatment preferences change, or
- or the patient's primary care professional changes.

**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                            | 5. Adult sibling                        |
| 2. Patient's spouse or partner of a registered civil union | 6. Adult grandchild                     |
| 3. Adult child   | 7. A close friend of the patient        |
| 4. Parent  | 8. The patient's guardian of the estate |

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**

## ORGAN DONATION: Our Final and Best Gift

Advances in medical technology over the past 30 years have allowed physicians to save lives, restore health and bring the gift of vision through the gift of organ donation.

Organ donation will occur only after everything has been done to save the donor's life and after death has been declared; the procedure is surgical, professional and dignified, and does not interfere with traditional funeral and burial customs. There is no cost to the family of the donor for these procedures.

Advance directives regarding organ donation can be made in a will, in a power of attorney for health care, through an organ donation card or driver's license notation, or by means of other written documents signed by the donor in the presence of two adult witnesses, who must also sign.

You may, at any time, change your mind about your decision by revoking or amending your will or other document or by writing "VOID" across the organ donation card.

Such a card is included in this brochure; in Illinois, you can also sign the reverse side of your driver's license to indicate your willingness to be an organ donor.

Because families are typically consulted before organ donation takes place, you should discuss your decision with your family and physician. ■

### ORGAN DONOR CARD

I, \_\_\_\_\_, hereby make the following anatomical gift, if medically acceptable, to take effect upon my death.

☐ **ANY ORGANS OR PARTS**    ☐ **ENTIRE BODY**

Only the following specific organs or parts:

\_\_\_\_\_  
Limitations or special wishes, if any:

\_\_\_\_\_  
(Signatures of donor and witnesses appear on reverse side.)

### POWER OF ATTORNEY FOR HEALTH CARE OR DECLARATION FOR MENTAL HEALTH TREATMENT

#### Notification Card

I, \_\_\_\_\_, have signed a Power of Attorney for Health Care or declaration for mental health treatment, authorizing my named agent to make all my health care decisions for me if I am unable to do so.

Agent name: \_\_\_\_\_

Day phone: \_\_\_\_\_ Eve. phone: \_\_\_\_\_

Successor agent name: \_\_\_\_\_

Day phone: \_\_\_\_\_ Eve. phone: \_\_\_\_\_





*If I am not for me,  
who will be?  
And if not now,  
when?*

**Organ Donor Card (side two)**

Signed by the donor and the following two witnesses in the presence of each other.

Donor Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date Signed: \_\_\_\_\_

City and State: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

This is a legal document under the Uniform Anatomical Gift Act or similar laws.

**LIVING WILL or POLST FORM**

*Notification Card*

I, \_\_\_\_\_, have signed a living will or a POLST form. If my condition is terminal, a copy may be obtained from:

Name: \_\_\_\_\_

Day phone: \_\_\_\_\_

Eve. phone: \_\_\_\_\_

Information about advance directives, including free print-at-home copies of *A Personal Decision*, is available at [www.isms.org/APD](http://www.isms.org/APD).

Contact [purchasing@isms.org](mailto:purchasing@isms.org) or 312-853-1638 to request additional print copies of *A Personal Decision*.

**Illinois State Medical Society**  
20 North Michigan Ave., Ste. 700  
Chicago, Illinois 60602  
312-782-1654  
800-782-4767



**Illinois  
State  
Medical  
Society**

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Illinois State Medical Society  
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Chicago, Illinois 60602  
312-782-1654  
800-782-4767

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