Your Right to Make Healthcare Decisions

Accepting Medical Treatment
Refusing Medical Treatment
Living Wills
Resuscitation Directives
Substitute Decision Makers
Medical Guardians
Includes these forms:
Medical Power of Attorney
Living Will
CPR Directive

For more information or downloadable versions of the forms included in this booklet visit www.ColoradoAdvanceDirectives.com

For help or more information about completing the forms, contact your local physician, hospital, senior group, attorney, or any of the organizations below:

Colorado Advance Directives Consortium
Colorado Bar Association
Colorado Department of Public Health and Environment
Colorado Department of Social Services
Colorado Hospital Association
Colorado Medical Society
Legal Aid Society
The Legal Center for Persons With Disabilities
...or a licensed healthcare facility.

Single copies of this booklet are available at no cost from the Colorado Hospital Association, 720-489-1630

To order multiple copies contact:

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303-923-0000
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YOUR RIGHT TO MAKE HEALTH CARE DECISIONS is provided through the Colorado Hospital Association as a public service to the community.

This booklet informs you about your right to make healthcare decisions, including the right to accept or refuse medical treatment.

It provides you with ready-to-use forms on which to record your decisions about medical treatment and your choice of the person you want to make decisions for you when you cannot.

These forms, and any written instructions you make ahead of time about your medical treatment, are called advance directives. This booklet explains the following advance directives and related subjects:

- Substitute Decision Makers: Medical Durable Power of Attorney, Proxy Decision Maker, Guardians
- Living Will
- Cardio-pulmonary Resuscitation (CPR Directive)
- Medical Orders for Scope of Treatment

FEDERAL LAW REQUIRES THAT YOU MUST BE GIVEN information on advance directives at the time you are admitted by any hospital, nursing home, HMO, hospice, home health care, or personal care program that receives federal funds (Medicare). You must also be given written information on policies of that facility or provider concerning advance directives.

If your advance directive conflicts with the facility’s policy or a particular healthcare professional’s moral or religious views, the facility or professional must transfer you to the care of another which will honor your advance directives.

You are not required to have advance directives in order to receive care and treatment, or for admission to a facility. You must only be informed about them. Whether or not you have advance directives, you will receive the medical care and treatment you need.

The advance directive forms in this booklet are specific to Colorado. If you spend a lot of time in another state, you should find out if your Colorado advance directives will be honored there. You may need to complete a separate set of advance directives according to the laws of that other state.

Revised January, 2011

This pamphlet was originally developed by the Advance Directives Coalition. This revision was prepared by the Colorado Advance Directives Consortium in collaboration with the Colorado Hospital Association.

Writing by Jennifer Ballentine, MA, cochair CADC
Design/layout by Bart Windrum, Axiom Action, LLC.
Addendum to Medical Durable Power of Attorney — recommended, not required

### 1. Signature of the Appointed Agent

I, \[Name\], having been informed of my appointment as a Healthcare Agent under Medical Durable Power of Attorney, understand that I am always to act in accordance with his or her wishes, not my own, and that I have full authority to speak with his or her healthcare providers, examine his or her medical records, and sign documents in order to carry out those wishes. I also understand that my authority as a Healthcare Agent is only in effect when the Declarant is unable to make decisions and that it automatically expires at his or her death.

---

### 2. Signature of Witnesses and Notary

This document was signed by \[Name of Declarant\].

In our presence, and we, in the presence of each other, and in the presence of the Declarant, have signed our names below as witnesses. We are at least eighteen (18) years old.

<table>
<thead>
<tr>
<th>Signature of Witness</th>
<th>Printed Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
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<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notary (optional)**

<table>
<thead>
<tr>
<th>State of</th>
<th>County of</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notary (optional)

Notary Public

My commission expires: ____________________________

---

**Pursuant to Colorado Revised Statute 15–14.503–509**

**Your Right to Make Health Care Decisions**

- **Competent adults (those able to make and express decisions)** have the right to:
  - Receive information in a way they can understand about the risks, benefits, alternatives, and likely outcomes of any recommended medical treatment;
  - Give consent to medical treatment;
  - Refuse medical treatment at any time for any reason, even if refusing medical treatment might result in death;
  - Make known their wishes regarding medical treatment in advance of needing the treatment;

---

**FEDERAL AND COLORADO STATE LAW both say that competent adults have the right to:**
- Receive information in a way they can understand about the risks, benefits, alternatives, and likely outcomes of any recommended medical treatment;
- Give consent to medical treatment;
- Refuse medical treatment at any time for any reason, even if refusing medical treatment might result in death;
- Make known their wishes regarding medical treatment in advance of needing the treatment.
I. Appointment of Agent and Alternates

<table>
<thead>
<tr>
<th>Declarant</th>
<th>Name of Agent</th>
<th>Agent's Best Contact Telephone Number</th>
<th>Agent's Email Address or alternative telephone number</th>
<th>Agent's home address</th>
<th>Name of Alternate Agent #1</th>
<th>Name of Alternate Agent #2</th>
<th>Agent's Best Contact Telephone Number</th>
<th>Agent's Email Address or alternative telephone number</th>
<th>Agent's home address</th>
</tr>
</thead>
</table>

II. When Agent's Powers Begin

- When the agent, as determined by a physician or another qualified medical professional, has determined that the declarant is unable to make or express any own decisions, and for as long as the declarant is unable to make or express any own decisions.

III. Instructions to Agent

- My agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way if I have not expressed a choice about the decision or healthcare to be provided.
- My agent shall have the authority to make the decisions on behalf of the declarant, and as the agent's decisions on behalf of the declarant, are consistent with the health wishes and preferences of the declarant.
- If the person named above is not available or is unable to continue as my Agent, then I appoint the following persons to serve in the order listed:

Some other things to consider:

- Pursuant to Colorado Revised Statute 15–14.503–509

Date

Signature of Declarant

I. Appointment of Agent and Alternates

- Declarant hereby appoints:

- Name of Agent

- Agent's Best Contact Telephone Number

- Agent's Email Address or alternative telephone number

- Agent's home address

- Name of Alternate Agent #1

- Name of Alternate Agent #2

- Agent's Best Contact Telephone Number

- Agent's Email Address or alternative telephone number

- Agent's home address

- If the person named above is not available or is unable to continue as my Agent, then I appoint the following person(s) to serve in the order listed:

- Name of Alternate Agent #1

- Name of Alternate Agent #2

- Agent's Best Contact Telephone Number

- Agent's Email Address or alternative telephone number

- Agent's home address
Advance Directive for Surgical / Medical Treatment (Living Will) (continued)

IV. CONSULTATION WITH OTHER PERSONS

I authorize my healthcare providers to discuss my condition and care with the following persons, understanding that... regarding my care, unless I have appointed them as my Health-care Agents under Medical Durable Power of Attorney.

V. NOTIFICATION OF OTHER PERSONS

Before withholding or withdrawing life-sustaining procedures, my healthcare providers shall make a reasonable effort to notify the following persons that I am in a terminal condition or Permanent Vegetative State. My healthcare providers have my permission to discuss my condition with these persons. I understand that I may appoint one or more people as my Agent(s) under Medical Durable Power of Attorney.

VI. ANATOMICAL GIFTS

Before my death, I authorize (check one or both)

☐ to donate my organs and/or tissues, if medically possible.
☐ not to donate my organs or tissues.

VII. SIGNATURE

I execute this declaration, as my free and voluntary act, this day of ________________________, 20____.

Notary (optional)

State of __________________________

County of ________________________

SUBSCRIBED and sworn to before me by

Notary Public

My commission expires: ____________________________

VIII. DECLARATION OF WITNESSES

We did not sign the Declarant's signature. We are not doctors or employees of the attending doctor or healthcare facility. We are not creditors nor heirs of the Declarant and have no claim against any portion of the Declarant's estate at the time this declaration was signed. We are at least eighteen (18) years old and under no pressure, undue influence, or otherwise disqualifying disability.

Notary (optional)

State of __________________________

County of ________________________

SUBSCRIBED and sworn to before me by

Notary Public

My commission expires: ____________________________

In some states, the law authorizes particular people in a particular order to act as substitute decision makers for an incapacitated patient: spouse first, adult children next, then parents, grandparents, siblings, etc. Colorado law does not have such a prioritized list of substitute decision makers. Instead, individuals, before they are incapacitated, should appoint a substitute decision maker, or healthcare agent. MEDICAL DURABLE POWER OF ATTORNEY You appoint your healthcare agent by completing a Medical Durable Power of Attorney (MDPOA) form. An MDPOA form, along with more information about the MDPOA/healthcare agent, is provided in this booklet. A healthcare agent only has authority to make healthcare decisions. An MDPOA cannot pay your bills, buy or sell real estate or other items of property for you, manage your bank accounts, etc. For that, you need to appoint a Financial or General Durable Power of Attorney. Forms to appoint other powers of attorney are available free from various Web sites or office supply stores, but it is a good idea to consult an attorney first. Low-cost legal advice is available from the Colorado Bar Association, www.cobar.org, or 303.860.1115. The written statements and documents you make to communicate your medical treatment decisions are called advance directives. In Colorado, there are three main types of advance directive: the Medical Durable Power of Attorney, the Living Will, and the CPR Directive. This booklet offers information and ready-to-use forms for all three. Other advance directive forms from other sources may be valid, too, if they follow Colorado law.

This booklet also briefly discusses the Medical Orders for Scope of Treatment (MOST). MOST is a summary of advance directives which, when signed by a healthcare professional, becomes a medical order set.

YOUR RIGHT TO APPOINT A SUBSTITUTE DECISION MAKER It can be very difficult to think ahead and imagine all the circumstances you might be in or the many healthcare decisions you might have to make. When people are very ill or badly injured, they are often unable to express their own decisions—they are incapacitated. Still, except in emergencies healthcare providers can’t just go ahead with treatment without consent from the patient. If the patient can’t give consent, someone else has to—but not just anybody else.
Anyone with a close interest in your care can be included in the group that
/T_h/T_h/Proxy Decision Maker for Healthcare or appointment of a guardian.
Proxy's decisions. If you later regain the ability to make and express your
wishes are not known, the Proxy must act in your best interests.
If you do not appoint a healthcare agent or MDPOA while you are able to
make your own decisions, Colorado law o
/ff/e Proxy must make an e
ffort to consult with you about the decisions to be
made and also must consult with the rest of the group. If the group cannot
agree that arti
6cial nour-
ishment would only prolong the moment of your death. Also, the Proxy's
may consult with your healthcare providers, review your
medical records, and make any and all decisions regarding your healthcare
except one: A Proxy Decision Maker cannot decide to withhold or withdraw
life-sustaining procedures (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, ______________________________________________ ,
communicate my own decisions. It is my direction that the following instructions be followed if I am diagnosed by two
physicians, one of whom is trained in neurology, agree that arti
al nourishment and hydration by tube, I direct
that one of the following actions be taken (initial one):

1. Life-Sustaining Procedures
   (initial one):
   - Artificial Nutrition and Hydration
     shall be continued for/unti (state: timeframe or goal):
   - Artificial Nutrition and Hydration shall not be continued.
   - Artificial Nutrition and Hydration shall be continued, if medically possible and advisable according to my healthcare providers.
   - Artificial Nutrition and Hydration shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

2. Artificial Nutrition and Hydration
   (initial one):
   - Artificial Nutrition and Hydration shall be continued for/unti (state: timeframe or goal):
   - Artificial Nutrition and Hydration shall not be continued.
   - Artificial Nutrition and Hydration shall be continued, if medically possible and advisable according to my healthcare providers.
   - Artificial Nutrition and Hydration shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

III. RESOLUTION WITH MEDICAL POWER OF ATTORNEY (initial one)
   Pursuant to Colorado Revised Statute 15–18.101–113
   (initial one): Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.
   - Artificial Nutrition and Hydration shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.
   - Artificial Nutrition and Hydration shall be continued for/unti (state: timeframe or goal):
   - Artificial Nutrition and Hydration shall not be continued.
   - Artificial Nutrition and Hydration shall be continued, if medically possible and advisable according to my healthcare providers.
   - Artificial Nutrition and Hydration shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

II. OTHER DIRECTIONS
   Please indicate below if you have attached to this form any
other instructions for your care a

A. Artificial Nutrition and Hydration
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   - Artificial Nutrition and Hydration shall be continued, if medically possible and advisable according to my healthcare providers.
   - Artificial Nutrition and Hydration shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

B. Persistent Vegetative State
   If at any time my physician/a
other qualified physician certifies in writing that I am in a Persistent Vegetative State, then:
   - Artificial Nutrition and Hydration shall be continued, if medically possible and advisable according to my healthcare providers.
   - Artificial Nutrition and Hydration shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

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   - Artificial Nutrition and Hydration shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.
A CPR Directive is a type of advance directive that you make for yourself or your behalf—to refuse resuscitation. CPR is an attempt to revive someone whose heart and/or breathing has stopped by using special drugs and/or resuscitation, and your heart and/or lungs stop or malfunction, then paralyzing, broken bones or comfort care.

A CPR Directive is not exactly the same as a DNR (Do Not Resuscitate) order, although many people refer to the CPR Directive as a DNR. A DNR order is an order written in your medical chart by your doctor while you are being cared for in a healthcare facility, such as a hospital or nursing home. The doctor will likely discuss this order with you or your surrogate decision maker, but does not have to. DNR orders are written when your doctor believes that resuscitation would not work or might cause more harm than good. (Fewer than 1 in 10 very elderly, frail, or seriously ill persons will survive a resuscitation attempt; if they do survive, they might end up with traumatic injuries or brain damage.) If you recover well enough to leave the facility, the DNR order expires at your discharge.

A CPR Directive is a type of advance directive that you make for yourself or an authorized decision maker makes for you, and it is valid outside of the healthcare facility. Signing a CPR Directive does not mean you won’t receive other medical care such as medicine, other treatment for pain, bleeding, broken bones or comfort care.

Anyone over the age of 18 can sign a CPR Directive. According to the CPR Directive law, a physician must also sign the CPR directive, indicating that you have been informed of what will happen if you refuse CPR and that refusal is appropriate due to your age or medical condition. You can revoke a CPR directive at any time by destroying it or by writing a statement that you revoke it on the form. If you sign a CPR directive for yourself, no one else can revoke it. If your agent, Proxy, or guardian signs one for you, they can revoke it.

Even if you have other types of advance directives, a CPR Directive is strongly recommended if you do not want to be resuscitated. Colorado law does not require that a specific CPR Directive form be used and copies, faxes, and scans of the form are also valid. A template prepared and approved by the Colorado Department of Public Health and Environment appears on the reverse side of this fold.

If you do sign a CPR directive, you should keep the form handy and visible so that emergency personnel or anyone else trying to help you in an emergency can see the form and understand your wishes. At home, place the CPR directive in a clearly marked envelope on your refrigerator, by your bedside, or by your front door. If you are out and about, carry one in your purse or wallet. A CPR alert bracelet or necklace can be ordered from Award and Sign Connection, www.AwardAndSign.com, 303-799-8979, or MedicAlert Foundation, www.MedicAlert.org, 888-633-4298.

CPR DIRECTIVES AND MINORS After a physician issues a Do Not Resuscitate order for a minor child—and only then—the parents of the minor, if married and living together, or the custodial parent or the legal guardian may execute a CPR Directive for the child. (CPR Directive continued)

THe MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST) form is a 1-page, 2-sided document that summarizes in check-box style choices for key life-sustaining treatments including CPR, general scope of treatment, antibiotics, and artificial nutrition and hydration. For each type of treatment, the patient may refuse treatment, request full treatment, or specify limitations.

The MOST is primarily intended for use by chronically or seriously ill persons in frequent contact with healthcare providers, or already living in a nursing facility. It is completed by the patient or authorized decision maker along with a Proxy to begin with, or if at any time the group cannot agree about particular decisions, the only option is for someone in the group to go to court to ask for appointment of a guardian.

GUARDIANS are appointed by the court to perform a certain set of duties on behalf of an incapacitated person. This person is called a ward or protected person. The law regards a person as being incapacitated when he or she is unable to make or communicate decisions concerning himself or herself. This may be due to mental illness, mental impairment, physical illness or disability, chronic use of drugs and/or alcohol, or other causes.

A court order might appoint a guardian to make medical care and treatment decisions or to manage the ward’s financial affairs. A court might appoint a limited guardian to provide particular services for a specific length of time. Generally the duties of a guardian are to decide where the ward should live; to arrange for necessary care, treatment, or other services for the ward; and to see that the basic daily personal needs of the ward are met, including food, clothing and shelter.

Any person aged 21 or over, or an appropriate agency, may be appointed as a guardian. Frequently, guardians are members of the ward’s family or close friends of the ward, but professional senior care managers and some county departments of Adult Protective Services may also serve as guardians. Guardianship can be shared by more than one individual; for instance, one person handling medical decisions and another financial. A guardian is not required to provide for a ward out of his or her own money, nor is he or she required to live with the ward. In addition, a guardian is not responsible for a ward’s behavior. It is important to know that, except in emergency situations, the court process to appoint a guardian may take several months.

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with a healthcare provider who can explain what each of the choices means for that patient at that time. Then it is signed by the patient or healthcare agent/Proxy and a physician, advanced practice nurse, or physician’s assistant. When signed, it becomes a medical order set, not an advance directive.

The MOST stays with the patient and is honored in any setting: hospital, clinic, day surgery, long-term care facility, assisted living residence, hospice, or at home. In this way, the MOST closes gaps in communication about treatment choices as patients transfer from setting to setting. The original is brightly colored for easy identification, but photocopies, faxes, and electronic scans are also valid.

The MOST does not replace or revoke advance directives. Choices on the MOST should be consistent with any advance directives the patient previously completed, but the MOST does not cover every treatment or instruction that might be addressed in an MDPOA or Living Will. The choices and directives documented there are still valid. The MOST overrules prior instructions only when there is a direct conflict. A section on the back prompts patients and providers to regularly review, confirm, or update choices based on changing conditions.

A MOST form is not included in this booklet; if you would like more information about the MOST form or program, please consult a healthcare provider or visit www.ColoradoAdvanceDirectives.com.

**ORGAN AND TISSUE DONATION** Any advance directive may include a written statement of your desire to donate organs or tissues. Please be aware that if you do wish to donate organs, your advance directive may be set aside for a time to allow your organs to be recovered before lifesustaining treatment is withdrawn (see section on the Living Will, page 11). If you refuse CPR, or cardio-pulmonary resuscitation, by executing a CPR directive (see page 13), you may not be able to donate organs, but you can still donate tissues, subject to some limitations of age, health status, and sexual orientation. For more information about organ and tissue donation, consult with your healthcare provider or contact Donor Alliance, www.DonorAlliance.org, or (303) 329-4747. If you do wish to donate organs or tissues, be sure your family knows your decision of this, as they will be asked to give consent to the donation procedure—and they have the final say.

**Patient’s Information**

<table>
<thead>
<tr>
<th>Patient’s Name</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Race Ethnicity</th>
<th>Eye Color</th>
<th>Hair Color</th>
<th>Physician’s Name</th>
<th>Physician’s Address</th>
<th>Physician’s License #</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Doe</td>
<td>02/02/1988</td>
<td>Male</td>
<td>White, non-Hispanic</td>
<td>Brown</td>
<td>Brown</td>
<td>John Smith</td>
<td>123 Main St, Denver</td>
<td>1234567890</td>
</tr>
</tbody>
</table>

**Physician’s Information**

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Gender</th>
<th>Race Ethnicity</th>
<th>Date</th>
<th>Signature of Patient</th>
<th>Signature of Physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/02/1988</td>
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<td>John Doe</td>
<td>John Smith</td>
</tr>
</tbody>
</table>

**Directive Attestation**

- **Cardio-Pulmonary Resuscitation (CPR):**
  - I hereby make an anatomical gift, to be effective upon my death of:
    - Skin
    - Bone, related tissues and tendons
    - Coronary arteries
    - Liver
    - Skin
  - I hereby direct emergency medical services personnel, health care providers, and any other person to withhold cardio-pulmonary resuscitation in the event that my/the patient’s heart or breathing stops or malfunctions. If I have been advised that CPR is not advisable for me, this directive shall be implemented as a physician’s order, pending further physician’s orders.

- **Tissue Donation:**
  - I hereby make an anatomical gift, to be effective upon my death of:
    - Skin
    - Bone, related tissues and tendons
    - Coronary arteries
  - I hereby direct emergency medical services personnel, health care providers, and any other person to withhold cardio-pulmonary resuscitation in the event that my/the patient’s heart or breathing stops or malfunctions. If I have been advised that CPR is not advisable for me, this directive shall be implemented as a physician’s order, pending further physician’s orders.

**Notes:**

- This template is available on the website of the Colorado Department of Public Health and Environment, www.CPR45ESR.com.
Medical Durable Power of Attorney

A MEDICAL DURABLE POWER OF ATTORNEY (MDPOA) is a document you sign naming someone to make your healthcare decisions if and when you are not able to. The person you name is called your healthcare agent. Your MDPOA can become effective immediately, or you can make it become effective only when you are unable to make your own medical decisions.

You can appoint anyone to be your healthcare agent as long as that person is at least 18 years old, mentally competent, and willing to be your agent. Your agent should also be someone who can confidently deal with lots of healthcare providers over what could be a long time. It is preferable to pick an agent who lives in the same state or even city as you do, and it’s also a good idea to pick one or two back-up agents, in case your first choice is not available or able to serve. Appointing more than one person as co-agents is not recommended.

Your healthcare agent has all the powers of decision making you do: He or she can consult with healthcare providers, review or get copies of your medical records, and make all necessary healthcare treatment and placement decisions. The agent must act according to his or her understanding of what your wishes and preferences would be. He or she must set aside his or her own values and preferences and do what you would do.

Therefore, it is very important to be sure your agent understands what your wishes are, what you consider to be acceptable, and when you would say no. Talk to your agent about your values, any religious or moral commitments you have, and your goals for treatment. What burdens of treatment (side effects, pain, nausea, fatigue, limitations on activity or thinking, etc.) are
acceptable to you and which are not? What benefits do you hope the treat-
ment will provide?

Do not assume that the person you pick to be your agent knows all of this,
just because he or she knows you well. Studies have shown that even spous-
es who have been married for decades are often wrong when asked to guess
what their partners would prefer! In fact, your spouse or life partner may
not be the best choice of agent, just because of his or her close involvement
in the outcome of your treatment. If you appoint your spouse as your agent,
and then later you are divorced, legally separated, or your marriage is an-
ulled, your former spouse is automatically removed as your agent unless
expressly stated otherwise in your MDPOA.

You may put instructions into your MDPOA document to help guide your
agent and your healthcare providers. A MDPOA form appears at the back
of this booklet.

Your MDPOA does not need to be witnessed or notarized. However, most
other states require witnesses, so if you plan to use your MDPOA in an-
other state, it’s a good idea to have it witnessed. You can cancel, or revoke,
your MDPOA at any time, assuming you have the mental capacity to do so,
and your agent can resign at any time. If you have not appointed a back-up
agent and can’t make decisions for yourself, then a Proxy Decision Maker
must be selected or a guardian appointed by the court.

Living Will

A LIVING WILL is a document you sign telling your doctors to
stop or not start life-sustaining treatments if you are in a terminal con-
dition and can’t make your own decisions or if you are in a persistent vegeta-
tive state (PVS). A terminal condition is one that is incurable or irreversible
and for which life-sustaining treatment will only postpone the moment of
death. Persistent vegetative state results from a severe brain injury and gen-
erally means that the person is alive and may appear to sleep and wake, but
is completely unaware of his or her surroundings; cannot speak, drink, or
eat; and may not be able to feel or react to pain.

A Living Will only goes into effect 48 hours after two doctors certify that
you are in a terminal condition and can’t make your own decisions or you
are in PVS. Your doctors must make a good effort to notify persons close
to you that this certification has been made and that they will withdraw or
withhold life-sustaining treatment within two days. You can include a list of
persons to be notified in the Living Will document, with their contact in-
formation. You can also include a list of persons authorized to talk to your
doctors about your condition and care. These persons are not authorized to
make any decisions about your care, however.

In Colorado, you may also designate in your Living Will that your doctors
should stop or not start any tube feeding and other forms of artificial nutri-
tion and hydration, once the terminal or PVS certification has been made,
unless they consider it is necessary to provide comfort or relieve pain. You
may also include other instructions about your care, but these instructions
will only go into effect at the same time as the Living Will: when your doc-
tors certify you are in a terminal condition and can’t make your own deci-
sions or you are in PVS. The Living Will is not the place to record general
acceptable to you and which are not? What benefits do you hope the treatment will provide?

Do not assume that the person you pick to be your agent knows all of this, just because he or she knows you well. Studies have shown that even spouses who have been married for decades are often wrong when asked to guess what their partners would prefer! In fact, your spouse or life partner may not be the best choice of agent, just because of his or her close involvement in the outcome of your treatment. If you appoint your spouse as your agent, and then later you are divorced, legally separated, or your marriage is annulled, your former spouse is automatically removed as your agent unless expressly stated otherwise in your MDPOA.

You may put instructions into your MDPOA document to help guide your agent and your healthcare providers. A MDPOA form appears at the back of this booklet.

Your MDPOA does not need to be witnessed or notarized. However, most other states require witnesses, so if you plan to use your MDPOA in another state, it’s a good idea to have it witnessed. You can cancel, or revoke, your MDPOA at any time, assuming you have the mental capacity to do so, and your agent can resign at any time. If you have not appointed a back-up agent and can’t make decisions for yourself, then a Proxy Decision Maker must be selected or a guardian appointed by the court.

(A Medical Durable Power of Attorney continued)

Living Will

A LIVING WILL is a document you sign telling your doctors to stop or not start life-sustaining treatments if you are in a terminal condition and can’t make your own decisions or if you are in a persistent vegetative state (PVS). A terminal condition is one that is incurable or irreversible and for which life-sustaining treatment will only postpone the moment of death. Persistent vegetative state results from a severe brain injury and generally means that the person is alive and may appear to sleep and wake, but is completely unaware of his or her surroundings; cannot speak, drink, or eat; and may not be able to feel or react to pain.

A Living Will only goes into effect 48 hours after two doctors certify that you are in a terminal condition and can’t make your own decisions or you are in PVS. Your doctors must make a good effort to notify persons close to you that this certification has been made and that they will withdraw or withhold life-sustaining treatment within two days. You can include a list of persons to be notified in the Living Will document, with their contact information. You can also include a list of persons authorized to talk to your doctors about your condition and care. These persons are not authorized to make any decisions about your care, however.

In Colorado, you may also designate in your Living Will that your doctors should stop or not start any tube feeding and other forms of artificial nutrition and hydration, once the terminal or PVS certification has been made, unless they consider it is necessary to provide comfort or relieve pain. You may also include other instructions about your care, but these instructions will only go into effect at the same time as the Living Will: when your doctors certify you are in a terminal condition and can’t make your own decisions or you are in PVS. The Living Will is not the place to record general
Medical Durable Power of Attorney

A MEDICAL DURABLE POWER OF ATTORNEY (MDPOA) is a document you sign naming someone to make your healthcare decisions if and when you are not able to. The person you name is called your healthcare agent. Your MDPOA can become effective immediately, or you can make it become effective only when you are unable to make your own medical decisions.

You can appoint anyone to be your healthcare agent as long as that person is at least 18 years old, mentally competent, and willing to be your agent. Your agent should also be someone who can confidently deal with lots of healthcare providers over what could be a long time. It is preferable to pick an agent who lives in the same state or even city as you do, and it’s also a good idea to pick one or two back-up agents, in case your first choice is not available or able to serve. Appointing two or more people as co-agents is not recommended.

Your healthcare agent has all the powers of decision making you do: He or she can consult with healthcare providers, review or get copies of your medical records, and make all necessary healthcare treatment and placement decisions. The agent must act according to his or her understanding of what your wishes and preferences would be. He or she must set aside his or her own values and preferences and do what you would do.

Therefore, it is very important to be sure your agent understands what your wishes are, what you consider to be acceptable, and when you would say no. Talk to your agent about your values, any religious or moral commitments you have, and your goals for treatment. What burdens of treatment (side effects, pain, nausea, fatigue, limitations on activity or thinking, etc.) are
CPR Directive

A CPR (CARDIO-PULMONARY RESUSCITATION) DIRECTIVE allows you—or your agent, guardian, or Proxy Decision Maker on your behalf—to refuse resuscitation. CPR is an attempt to revive someone whose heart and/or breathing has stopped by using special drugs and/or machines or by firmly and repeatedly pressing the chest. If you have a CPR Directive and your heart and/or lungs stop or malfunction, your consent to CPR is assumed. However, if you have a CPR Directive refusing resuscitation, and your heart and/or lungs stop or malfunction, then paramedics and doctors, emergency personnel or others will not press on your chest or use breathing tubes, electric shock, or other procedures to get your heart and/or lungs working again.

A CPR Directive is not exactly the same as a DNR (Do Not Resuscitate) order, although many people refer to the CPR Directive as a DNR. A CPR order, or an order written in your medical chart by your doctor while you are being cared for in a healthcare facility, such as a hospital or nursing home. The doctor will likely discuss this order with you or your surrogate decision maker, but does not have to. DNR orders are written when your doctor believes that resuscitation would not work or might cause more harm than good. (Fewer than 1 in 10 very elderly, frail, or seriously ill persons will survive a resuscitation attempt; if they do survive, they might end up with traumatic injuries or brain damage.) If you recover well enough to leave the facility, the DNR order expires at your discharge.

A CPR Directive is a type of advance directive that you make for yourself or an authorized decision maker makes for you, and it is valid outside of the healthcare facility. Signing a CPR Directive does not mean you won't receive other medical care such as medicine, other treatment for pain, bleeding, broken bones or comfort care.

(continued)

(CPR Directive continued)

Anyone over the age of 18 can sign a CPR Directive. According to the CPR Directive law, a physician must also sign the CPR directive, indicating that you have been informed of what will happen if you refuse CPR and that refusal is appropriate due to your age or medical condition. You can revoke a CPR directive at any time by destroying it or by writing a statement that you revoke it on the form. If you sign a CPR directive for yourself, no one else can revoke it. If your agent, Proxy, or guardian signs one for you, they can revoke it.

Even if you have other types of advance directives, a CPR Directive is strongly recommended if you do not want to be resuscitated. Colorado law does not require that a specific CPR Directive form be used and copies, fax-es, and scans of the form are also valid. A template prepared and approved by the Colorado Department of Public Health and Environment appears on the reverse side of this fold.

If you do sign a CPR directive, you should keep the form handy and visible so that emergency personnel or anyone else trying to help you in an emergency can see the form and understand your wishes. At home, place the CPR directive in a clearly marked envelope on your refrigerator, by your bedside, or by your front door. If you are out and about, carry one in your purse or wallet. A CPR alert bracelet or necklace can be ordered from Award and Sign Connection, www.AwardAndSign.com, 303-799-8979, or (800) 548-8711.

CPR DIRECTIVES AND MINORS

A physician issues a Do Not Resuscitate order for a minor child—and only then—the parents of the minor, if married and living together, or the custodial parent or the legal guardian may execute a CPR Directive for the child.

THe MEDICAL ORDERS FOR SCOPE OF TREATMENT (MOST) FORM is a 1-page, 2-sided document that summarizes in check-box style choices for key life-sustaining treatments including CPR, general scope of treatment, antibiotics, and artificial nutrition and hydration. For each type of treatment, the patient may refuse treatment, request full treatment, or specify limitations. The MOST is primarily intended for use by chronically or seriously ill persons in frequent contact with healthcare providers, or already living in a nursing facility. It is completed by the patient or authorized decision maker along
A CPR Directive is a type of advance directive that you make for yourself or your behalf—to refuse resuscitation. CPR is an attempt to revive someone whose heart and/or breathing has stopped by using special drugs and/or machines or by firmly and repeatedly pressing the chest. If you have a CPR Directive and your heart and/or lungs stop or malfunction, your consent to CPR is assumed. However, if you have a CPR Directive refusing resuscitation, and your heart and/or lungs stop or malfunction, then paramedics and doctors, emergency personnel or others will not press on your chest or use breathing tubes, electric shock, or other procedures to get your heart and/or lungs working again.

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A CPR Directive is a type of advance directive that you make for yourself or an authorized decision maker makes for you, and it is valid outside of the healthcare facility. Signing a CPR Directive does not mean you won't receive other medical care such as medicine, other treatment for pain, bleeding, broken bones or comfort care.

(CPR Directive continued)

Anyone over the age of 18 can sign a CPR Directive. According to the CPR Directive law, a physician must also sign the CPR directive, indicating that you have been informed of what will happen if you refuse CPR and that refusal is appropriate due to your age or medical condition. You can revoke a CPR directive at any time by destroying it or by writing a statement that you revoke it on the form. If you sign a CPR directive for yourself, no one else can revoke it. If your agent, Proxy, or guardian signs one for you, they can revoke it. Even if you have other types of advance directives, a CPR Directive is strongly recommended if you do not want to be resuscitated. Colorado law does not require that a specific CPR Directive form be used and copies, faxes, and scans of the form are also valid. A template prepared and approved by the Colorado Department of Public Health and Environment appears on the reverse side of this fold.

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CPR DIRECTIVES AND MINORS

After a physician issues a Do Not Resuscitate order for a minor child—and only then—the parents of the minor, if married and living together, or the custodial parent or the legal guardian may execute a CPR Directive for the child.

(CPR Directive continued)

The medical orders for scope of treatment (MOST) form is a 1-page, 2-sided document that summarizes in check-box style choices for key life-sustaining treatments including CPR, general scope of treatment, antibiotics, and artificial nutrition and hydration. For each type of treatment, the patient may refuse treatment, request full treatment, or specify limitations. The MOST is primarily intended for use by chronically or seriously ill persons in frequent contact with healthcare providers, or already living in a nursing facility. It is completed by the patient or authorized decision maker along with a physician who was involved in the patient's care within the last twelve months.

A court order might appoint a guardian to make medical care and treatment decisions or to manage the ward's financial affairs. A court might appoint a limited guardian to provide particular services for a specific length of time. Generally the duties of a guardian are to decide where the ward should live; to arrange for necessary care, treatment, or other services for the ward; and to see that the basic daily personal needs of the ward are met, including food, clothing and shelter.

Any person aged 21 or over, or an appropriate agency, may be appointed as a guardian. Frequently, guardians are members of the ward's family or close friends of the ward, but professional senior care managers and some county departments of Adult Protective Services may also serve as guardians.

Guardianship can be shared by more than one individual; for instance, one person handling medical decisions and another financial. A guardian is not required to provide for a ward out of his or her own money, nor is he or she required to live with the ward. In addition, a guardian is not responsible for a ward's behavior. It is important to know that, except in emergency situations, the court process to appoint a guardian may take several months.
YOUR RIGHT TO MAKE HEALTH CARE DECISIONS is provided through the Colorado Hospital Association as a public service to the community.

This booklet informs you about your right to make healthcare decisions, including the right to accept or refuse medical treatment.

It provides you with ready-to-use forms on which to record your decisions about medical treatment and your choice of the person you want to make decisions for you when you cannot.

These forms, and any written instructions you make ahead of time about your medical treatment, are called advance directives. This booklet explains the following advance directives and related subjects:

- Substitute Decision Makers: Medical Durable Power of Attorney, Proxy Decision Maker, Guardians
- Living Will
- Cardio-pulmonary Resuscitation (CPR Directive)
- Medical Orders for Scope of Treatment

FEDERAL LAW REQUIRES THAT YOU MUST BE GIVEN information on advance directives at the time you are admitted by any hospital, nursing home, HMO, hospice, home health care, or personal care program that receives federal funds (Medicare). You must also be given written information on policies of that facility or provider concerning advance directives.

If your advance directive conflicts with the facility’s policy or a particular healthcare professional's moral or religious views, the facility or professional must transfer you to the care of another which will honor your advance directives.

You are not required to have advance directives in order to receive care and treatment, or for admission to a facility. You must only be informed about them. Whether or not you have advance directives, you will receive the medical care and treatment you need.

The advance directive forms in this booklet are specific to Colorado. If you spend a lot of time in another state, you should find out if your Colorado advance directives will be honored there. You may need to complete a separate set of advance directives according to the laws of that other state.
Your Right to Make Healthcare Decisions

Accepting Medical Treatment
Refusing Medical Treatment
Living Wills
Resuscitation Directives
Substitute Decision Makers
Medical Guardians
Includes these forms:
Medical Power of Attorney
Living Will
CPR Directive

For more information or downloadable versions of the forms included in this booklet visit www.ColoradoAdvanceDirectives.com

For help or more information about completing the forms, contact your local physician, hospital, senior group, attorney, or any of the organizations below:

- Colorado Advance Directives Consortium
- Colorado Bar Association
- Colorado Department of Public Health and Environment
- Colorado Department of Social Services
- Colorado Hospital Association
- Colorado Medical Society
- Legal Aid Society
- The Legal Center for Persons With Disabilities
  …or a licensed healthcare facility.

Single copies of this booklet are available at no cost from the Colorado Hospital Association, 720-489-1630

To order multiple copies contact:

Progressive Services, Inc.
1925 S. Rosemary Street, #H, Denver, CO 80231
303-923-0000
Fax 303-923-0001
www.PrintWithPSI.com

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I. Appointment of Agent and Alternates

1. Declarant, hereby appoint:

   Name of Agent

   Agent’s Best Contact Telephone Number

   Agent’s email or alternative telephone number

   Agent’s home address

   as my Agent to make and communicate my healthcare decisions when I cannot. This gives my Agent the power to consent to, or refuse, or stop any healthcare, treatment, service, or diagnostic procedure. My Agent also has the authority to talk with healthcare personnel, get information, and sign forms as necessary to carry out those decisions.

If the person named above is not available or is unable to communicate or make decisions, to the extent possible, consult me on the decisions and make every effort to enable my understanding and make my or express my own decisions, and for as long as I am unable to make or express my own decisions, and for as long as I am unable to make or express my own decisions. And you have the right to communicate or make decisions. In order to make sure your wishes are expected or possible, and whether there are any alternatives.

By this document, I intend to create a Medical Durable Power of Attorney which shall take effect either (initial one):

   (Initials) Immediately upon my signature.

   (Initials) When my physician or other qualified medical professional has determined that I am unable to make or express my own decisions, and for as long as I am unable to make or express my own decisions.

III. Instructions to Agent

My Agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way. If I have not expressed a choice about the decision or healthcare in question, my Agent shall base his or her decisions on what he or she, in consultation with my healthcare providers, determines is in my best interest. I also request that my Agent, to the extent possible, consult me on the decisions and make every effort to enable my understanding and find out my preferences.

State here any desires concerning life-sustaining procedures, treatment, general care and services, including any special provisions or limitations:

Pursuant to Colorado Revised Statute 15–14.503–509
Addendum to Medical Durable Power of Attorney — recommended, not required

1. Signature of the Appointed Agent

Although not required by Colorado law, my signature below indicates that I have been informed of my appointment as a Healthcare Agent under Medical Durable Power of Attorney for (name of Declarant)

I am at least eighteen (18) years old. I accept the responsibilities of that appointment, and I have discussed with the Declarant his or her wishes and preferences for medical care in the event that he or she cannot speak for him- or herself.

I understand that I am always to act in accordance with his or her wishes, not my own, and that I have full authority to speak with his or her healthcare providers, examine healthcare records, and sign documents in order to carry out those wishes. I also understand that my authority as a Healthcare Agent is only in effect when the Declarant is unable to make his or her own decisions and that it automatically expires at his or her death.

If I am an alternate Agent, I understand that my responsibilities and powers will only take effect if the primary Agent is unable or unwilling to serve.

Primary Agent's Signature

Printed Name

Date

Alternate Agent #1 Signature

Printed Name

Date

Alternate Agent #2 Signature

Printed Name

Date

Pursuant to Colorado Revised Statute 15–14.503–509

2. Signature of Witnesses and Notary

The signature of two witnesses and a notary are not required by Colorado law for proper execution of a Medical Durable Power of Attorney; however, they may make the document more acceptable in other states.

This document was signed by (name of Declarant)

in our presence, and we, in the presence of each other, and at the Declarant’s request, have signed our names below as witnesses. We are at least eighteen (18) years old.

Signature of Witness

Printed Name

Address

Signature of Witness

Printed Name

Address

Notary (optional)

State of ____________________________________________________________

County of __________________________________________________________

Notary Public

Date

Notary Public

Date

If you have other advance directives under Colorado law, they may still be valid in Colorado. However, it is recommended that you prepare new directives under Colorado law to replace your other directives.

Your Right to Make Health Care Decisions

By preparing Your Right to Make Health Care Decisions under Colorado law, You have the right to make, in advance, decisions about Your care if You are unable to do so at a later time. The scope of Your advance directives may vary. You may make a durable power of attorney for health care, a living will, and a mental health power of attorney.

In preparing and signing (or granting) an advance directive, it is important to think about both the legal and medical implications. You should discuss your decisions with Your primary doctor, other healthcare providers, and any other people You trust. You may want to entrust a trusted health care advocate to help You make Your decisions. You should keep a copy of Your advance directive in a safe deposit box. Give copies of Your advance directive to family members and friends who will know Your wishes.

As Your health changes, You may want to update Your advance directive. It is important to re-review Your advance directive every few years. Do not change Your directives without discussing them with Your primary doctor and other healthcare providers. In the event of a disagreement, refer to the directive that is in effect.

To keep up to date on the legal and medical aspects of health care advanced directives, visit the website of the Colorado Medical Society at www.co-medsoc.org. The Department of Health Care Policy and Management at the University of Colorado Medical School provides a complete set of forms and instructions, including sample directives under Colorado law.

Your advance directive is not a contract with Your healthcare provider. It is an expression of Your wishes and is advisory in nature. Your healthcare provider is under no legal obligation to follow the terms of Your advance directive. Your advance directive may be overridden if medical treatment is required to save Your life. You should also be aware that in some cases, the terms of Your advance directive may be unenforceable.
Advocate Directive for Surgical / Medical Treatment (Living Will)

On completion, give copies to your physician, family members, and Healthcare Agent. If you wish to revoke or replace this document, mark it clearly as “Revoked” or destroy it and all its copies, if possible. If you do not understand the choices and options, seek advice from a healthcare provider or other qualified advisor.

I. DECLARATION

I, ____________________________________________, am at least eighteen (18) years old 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 qualified physicians, one of whom is trained in neurology, that I have a terminal condition.

A. Terminal Condition

If at any time my 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)

   (initials) 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.

   (initials) I direct that life-sustaining procedures shall 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):

   (initials) Artificial nutrition and hydration shall not be continued.

   (initials) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

   (initials) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

B. Persistent Vegetative State

If at any time my physician and one other qualified physician certify in writing that I am in a Persistent Vegetative State, then:

1. Life-Sustaining Procedures (initial one)

   (initials) I direct that 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.

   (initials) I direct that life-sustaining procedures shall be continued for/until (state timeframe or goal):

II. OTHER DIRECTIONS

Please indicate below if you have attached to this form any other instructions for your care after you are certificated in a terminal condition or 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.) (initial one):

   (initials) Yes, I have attached another directions.

   (initials) No, I do not have any other directions.

III. RESOLUTION WITH MEDICAL POWER OF ATTORNEY (initial one)

   (initials) My Agent under my Medical Durable Power of Attorney shall have the authority to override any of the directions stated here, whether I signed this declaration before or after I appointed that Agent.

   (initials) My directions as stated here may not be overridden or revoked by my Agent under Medical Durable Power of Attorney, whether I signed this declaration before or after I appointed that Agent.
Advance Directive for Surgical / Medical Treatment (Living Will) (continued)

IV. 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 Medical Durable Power of Attorney.

Name

Relationship


V. NOTIFICATION OF OTHER PERSONS

Before withholding or withdrawing life-sustaining procedures, my healthcare providers shall make a reasonable effort to notify the following persons that I am in a terminal condition or Persistent Vegetative State. My healthcare providers have my permission to discuss my condition with these persons. I do NOT authorize these persons to make medical decisions on my behalf, unless I have appointed one or more of them as my Agent(s) under Medical Durable Power of Attorney.

Name

Telephone number or email


VI. ANATOMICAL GIFTS

☐ organs and/or ☐ tissues, if medically possible.

VII. SIGNATURE

I execute this declaration, as my free and voluntary act, this day of _________________________, 20____.

Declarant signature

VIII. DECLARATION OF WITNESSES

This declaration was signed by (name of Declarant) in our presence, and we, in the presence of each other, and at the Declarant’s request, have signed our names below as witnesses. We did not sign the Declarant’s signature. We are not doctors or employees of the attending doctor or healthcare facility in which the Declarant is a patient. We are neither creditors nor heirs of the Declarant and have no claim against any portion of the Declarant’s estate at the time this declaration was signed. We are at least eighteen (18) years old and under no pressure, undue influence, or otherwise disqualifying disability.

Signature of Witness

Printed Name

Address

Signature of Witness

Printed Name

Address

Notary (optional)

State of

County of

Notary Public

SUBSCRIBED and sworn to before me by , the Declarant, and witnesses, as the voluntary act and deed of the Declarant this day of , 20____.

Notary Public

My commission expires: ____________________________

Pursuant to Colorado Revised Statute 15–18.101–113

...
Patient’s or Authorized Agent’s Directive to Withhold Cardiopulmonary Resuscitation (CPR)

This template is consistent with rules adopted by the Colorado State Board of Health at 6 CCR 1015-2.

**Patient’s Information**

Patient’s Name ________________________________ (Printed Name)

If Applicable Name of Agent/Legally Authorized Guardian/Parent of Minor Child ________________________________ (Printed Name)

Date of Birth _____ / _____ / ______ Gender □ Male □ Female □ Eye Color _______ □ Hair Color _______

Race Ethnicity □ Asian or Pacific Islander □ Black, non-Hispanic □ White, non-Hispanic □ American Indian or Alaska Native □ Hispanic □ Other

If Applicable Name of hospice program/provider ________________________________

**Physician’s Information**

Physician’s Name ________________________________ (Printed Name)

Physician’s Address ________________________________

Physician’s telephone ( ) ___________________________ Physician’s Colorado License # __________________

**Directive Attestation**

Check ONLY the information that applies:

□ Patient I am over the age of 18 years, of sound mind and acting voluntarily. It is my desire to initiate this directive on my behalf. I have been advised that as a result of this directive, if my heart or breathing stops or malfunctions, I will not receive CPR and I may die.

□ Authorized Agent/Legally Authorized Guardian/Parent of Minor Child I am over the age of 18 years, of sound mind, and I am legally authorized to act on behalf of the patient named above in the issuance of this directive. I have been advised that as a result of this directive, if the patient’s heart or breathing stops or malfunctions, the patient will not receive CPR and may die.

□ Tissue Donation I hereby make an anatomical gift, to be effective upon my death of:

□ Any needed tissues

The following tissues □ Skin □ Cornea □ Bone, related tissues and tendons

I hereby direct emergency medical services personnel, health care providers, and any other person to withhold cardiopulmonary resuscitation in the event that my/the patient’s heart or breathing stops or malfunctions. I understand that this directive does not constitute refusal of other medical interventions for my/the patient’s care and comfort. If I/the patient am/is admitted to a healthcare facility, this directive shall be implemented as a physician’s order, pending further physician’s orders.

□ Signature of Patient □ Authorized Agent/Legally Authorized Guardian/Parent of Minor Child

Date ___________________________ Date ___________________________