PATIENT PACKET

NEW ORLEANS MUSICIANS' CLINIC

The New Orleans Musicians' Clinic Advance Directive
Living Will & Durable Power of Attorney for Health Care

*****Please be sure to initial and date every page*****

1. LIVING WILL

A. Information and Instructions

A Living Will lets you write down how you wish to be treated in case you aren't able to speak for yourself anymore. This document is given to your family, your physician(s), your attorney, your clergyman, your medical facility in whose care you happen to be, and to any individual who may become responsible for your health, welfare or affairs, including your Health Care Agent, if you choose to appoint one.

In the Living Will, you give instructions for situations where you have an incurable injury, disease or illness or are in a continual profound comatose state with no reasonable chance of recovery and death will occur whether or not life sustaining or heroic measures are used, determined by two physicians, including your attending physician. You may choose to withhold or withdraw "heroic" or life sustaining measures that only serve only to artificially prolong the dying process so that you are permitted to die naturally. Some examples of life-sustaining treatments are:

- CPR (cardiopulmonary resuscitation)
- A breathing machine (mechanical ventilation)
- Kidney dialysis
- A feeding tube (artificial nutrition and hydration)

Comfort measures and care, including pain medication, are *not* considered a life sustaining procedure.

In the Living Will, you are determining that if you are unable to give directions regarding the use of life-prolonging procedures, it is your intention that your declaration shall be honored by your family, Health Care Agent (if you have appointed one) and physician as the final expression of your legal right to refuse or withdraw medical or surgical treatment and accept the consequences of that decision.

The Living Will must be signed by you in the presence of two witnesses. Each witness must be a competent adult who is not related to you by blood or marriage and who would not be entitled to any portion your estate upon your death.

B. <u>My LIVING WILL</u> – A Declaration About Life-Sustaining Treatments

SKIP THIS SECTION IF YOU DO NOT WISH TO SIGN A LIVING WILL.

I, _____, a resident New Orleans, Orleans Parish, Louisiana, being of sound and disposing mind, memory and understanding, do hereby willfully and voluntarily make, publish and declare this to be my LIVING WILL, making known my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

If at any time I should have an incurable injury, disease or illness, or be in a continual profound comatose state with no reasonable chance of recovery, certified to be a terminal and irreversible condition by two physicians who have personally examined me, including my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would only serve to prolong artificially the dying process, I direct:

<u>INITIAL ONLY ONE</u>:

_____ That all life sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.

_____ That life sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

I also provide the following instructions if I am unable to communicate my wishes:

_____

_____

I further direct that I be permitted to die naturally with only the administration of medication or other medical procedures necessary to provide me with comfort care.

If I am unable to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family, my Health Care Agent (if I have identified one below) and the physicians treating me as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

_____

Declarant Signature / Date / Address

The Declarant is known to me and I believe Declarant to be of sound mind. I am not related by blood or marriage to Declarant and, to the best knowledge and reasonable belief, am not entitled to any portion of Declarant's estate upon his death.

_____	_____
Witness 1 / Date	Witness 2 / Date
_____	_____
Witness 1 Printed Name	Witness 2 Printed Name
_____	_____
Witness 1 Address	Witness 2 Address

2. Health Care Agent

A. Information and Instructions:

You may appoint a specific person to make health care decisions for you if your medical condition makes it impossible for you to make decisions for yourself.

This person is called your **Health Care Agent**. If you are unable to make decisions for yourself, your Health Care Agent will have the authority to make all health care decisions for you and in accordance with your Living Will, if you have one. This includes decisions to admit and discharge you from any hospital or other health care institution and to make decisions to start or stop any type of health care treatment.

Your **Health Care Agent** can access your personal health information, including your medical records.

Your **Health Care Agent** should be someone:

1. You trust;

2. Who knows you well; and

3. Who is familiar with your values and beliefs.

PLEASE NOTE: Information about whether you have been tested for HIV or treated for AIDS, sickle cell anemia, substance abuse or alcoholism will only be shared with your Health Care Agent under very limited circumstances.

If you wish to give permission for LSUHN/ NOMC to share this information with your Health Care Agent, you will need to give special written consent.

LSUHN/NOMC staff is available to provide you with additional information or authorization forms to allow your Health Care Agent access to this information.

2. MY HEALTH CARE AGENT

SKIP THIS SECTION IF YOU DO NOT WISH TO APPOINT A HEALTH CARE AGENT.

I, _____, a resident of the New Orleans, Orleans Parish, Louisiana, being of sound and disposing mind, memory and understanding, do hereby willfully and voluntarily authorize

_____

_____
Full Name / Address / Telephone Number / Email

to make all medical treatment decisions for me, including decisions to withhold or withdraw any form of life sustaining procedure on by behalf should I be diagnosed (1) as suffering from a terminal and irreversible condition; and (2) comatose, incompetent or otherwise mentally or physically incapable of communication.

INITIAL ONE:

_____ I have expressed my directions regarding the use of such life-sustaining procedures in a Living Will and it is my intention that my Health Care Agent shall honor the declaration set forth in this document as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

_____ I have not declared intentions in the Living Will section of this document.

I understand the full importance of the appointment of a Health Care Agent and make this designation voluntarily.

_____
Declarant Signature / Date / Address

The Declarant is known to me and I believe Declarant to be of sound mind. I am not related by blood or marriage to Declarant and, to the best knowledge and reasonable belief, am not entitled to any portion of Declarant's estate upon his death.

_____ _____
Witness 1 / Date Witness 2 / Date

_____ _____
Witness 1 Printed Name Witness 2 Printed Name

_____ _____
Witness 1 Address Witness 2 Address