HOSPICE OF ACADIANA

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Decision Making

Data Station

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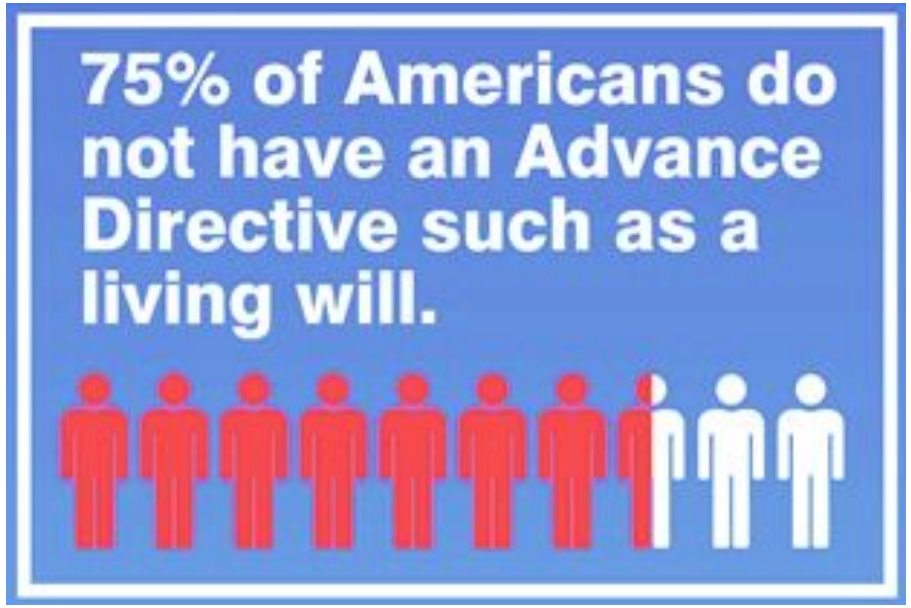
Did you know?



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Action Steps

Stage 1	Stage 2	Stage 3
Create your Advance Directive … as a healthy adult.	Review and update Advance Directive as needed … if diagnosed with a serious illness.	Update Advance Directive and consider a LaPost Form … if you are very sick or frail.

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Let's Consider …

- HELLO Project
  - Conversation Starter; Pre-cursor to Advance Directives
- Advance Directives (Ex: Five Wishes)
  - Types of Decisions to be Made
  - Who Speaks on Your Behalf
  - What They Should Say
- Living Wills; Power of Attorney (Durable, Medical)
- LaPOST Form

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Start with HELLO!

- Conversation Starter
- Game-type Setting
- Upcoming Sessions –
  Hospice of Acadiana

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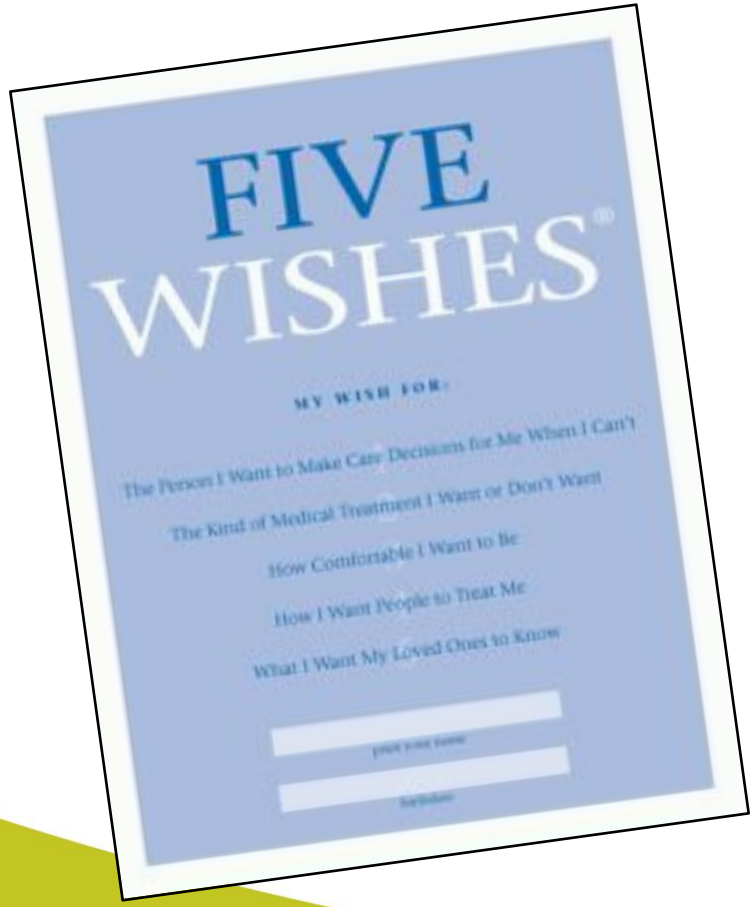
Advance Directives



Advance Care Planning provides individuals with peace and assurance that their wishes and preferences are known when a health care crisis or life-threatening illness occurs.

(Example: Five Wishes)

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What is an Advance Directive?

… a legal document that goes into effect only if you are incapacitated and unable to speak for yourself …

- Who I want to make care decisions for me when or if I am not able
- What I want my loved ones to know
- What kind of medical treatment I do or don't want
- How I want people to treat me
- How comfortable I want to be

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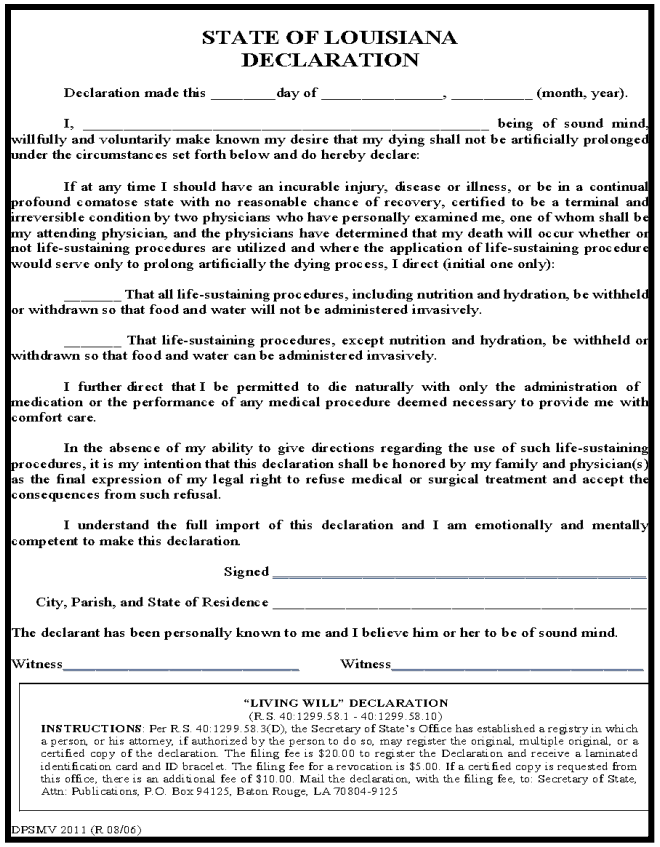
Living Will



STATE OF LOUISIANA
DECLARATION

Declaration made this _____day of _____, _____ (month, year).

I, _____ being of sound mind, willfully and voluntarily make known my desire that my dying 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, one of whom shall be 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 procedure would serve only to prolong artificially the dying process, I direct (initial one only):

_____ 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 further direct that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____

City, Parish, and State of Residence _____

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness_____ Witness_____

"LIVING WILL" DECLARATION
(R.S. 40:1299.58.1 - 40:1299.58.10)

INSTRUCTIONS: Per R.S. 40:1299.58.3(D), the Secretary of State's Office has established a registry in which a person, or his attorney, if authorized by the person to do so, may register the original, multiple original, or a certified copy of the declaration. The filing fee is $20.00 to register the Declaration and receive a laminated identification card and ID bracelet. The filing fee for a revocation is $5.00. If a certified copy is requested from this office, there is an additional fee of $10.00. Mail the declaration, with the filing fee, to: Secretary of State, Attn: Publications, P.O. Box 94125, Baton Rouge, LA 70804-9125

DPSMV 2011 (R 08/06)

- **Written document**
- **Tells doctors how you want to be treated if:**
  - you are dying or permanently unconscious
  - you cannot make your own decisions about emergency treatment.
- **Can state:**
  - which procedures you would want
  - which ones you wouldn't want
  - the conditions under which your choices apply

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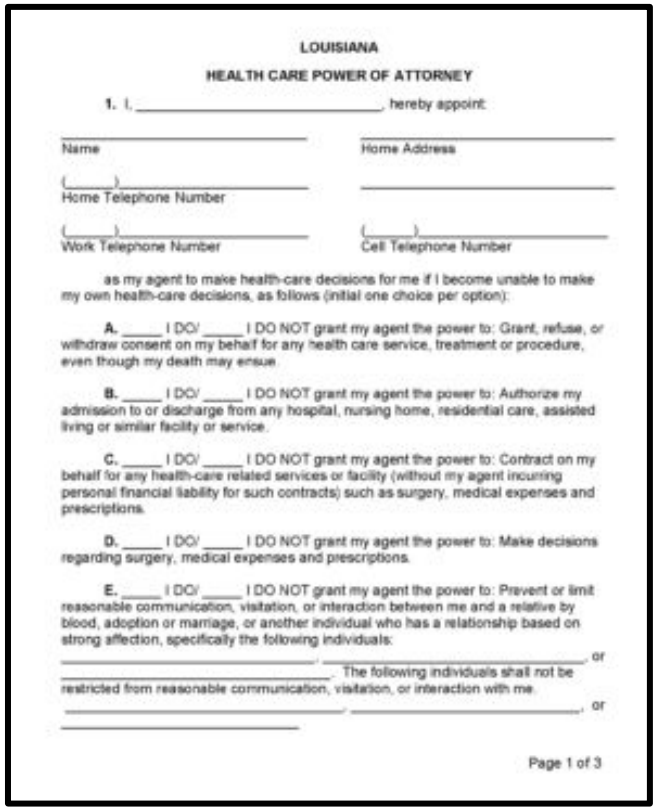
Health Care Power of Attorney



LOUISIANA

HEALTH CARE POWER OF ATTORNEY

1. I, _____, hereby appoint:

_____ Name

_____ Home Address

(_____)_____ Home Telephone Number

_____

(_____)_____ Work Telephone Number

(_____)_____ Cell Telephone Number

as my agent to make health-care decisions for me if I become unable to make my own health-care decisions, as follows (initial one choice per option):

A. _____ I DO/ _____ I DO NOT grant my agent the power to: Grant, refuse, or withdraw consent on my behalf for any health care service, treatment or procedure, even though my death may ensue.

B. _____ I DO/ _____ I DO NOT grant my agent the power to: Authorize my admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service.

C. _____ I DO/ _____ I DO NOT grant my agent the power to: Contract on my behalf for any health-care related services or facility (without my agent incurring personal financial liability for such contracts) such as surgery, medical expenses and prescriptions.

D. _____ I DO/ _____ I DO NOT grant my agent the power to: Make decisions regarding surgery, medical expenses and prescriptions.

E. _____ I DO/ _____ I DO NOT grant my agent the power to: Prevent or limit reasonable communication, visitation, or interaction between me and a relative by blood, adoption or marriage, or another individual who has a relationship based on strong affection, specifically the following individuals:

_____, _____, or _____. The following individuals shall not be restricted from reasonable communication, visitation, or interaction with me.

_____, _____, or _____

Page 1 of 3

- Legal document
- Grants a person or organization permission to make healthcare decisions for you when you cannot do so
- Example:
  - Requesting or refusing a medical treatment or procedure

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LaPost Form


LOUISIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (LaPOST)

- Louisiana Physician Orders for Scope of Treatment (LaPOST)
- Voluntary document
- Allows individuals to state preferences for kinds of care they would like to receive
- Used when facing serious, advanced illness that may eventually limit ability to speak or direct own care

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Benefits of Planning Ahead

- Alleviates unnecessary suffering
- Improves quality of life
- Provides better understanding of the decision-making challenges for the patient and their loved ones
- Relieves stress on the family
- Aids healthcare professionals when providing care