Evanston Regional Hospital
190 Arrowhead Drive
Evanston, WY 82930
(307) 789-3636

Wyoming Advance Health Care Directive Form For:

_____

(Print your full name)

Please place the completed document on the front of your refrigerator or another location where an emergency responder might easily see it.

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Wyoming Advance Health Care Directive Form Guidance and Glossary

You have the right to give instructions about your own health care. You also have the right to name someone else to make health-care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs.

Unless you state otherwise, your agent may make all health-care decisions for you. This form has a place for you to limit the authority of your agent. Unless you limit the authority of your agent, your agent will have the right to:

a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;

b) Select or dismiss health-care providers and institutions;

c) Approve or deny diagnostic tests, surgical procedures, medication and orders not to resuscitate; and

d) Direct the provision, withholding or withdrawal of artificial nutrition and hydration and all other forms of health care.

If you use this form, you may choose whether to complete all or any part of it or you may modify any part of it. You also are free to use a different form. Once you have completed the form:

1. Give a copy of the signed and completed form to your primary physician, to any other health-care providers you may have, to any health-care institution at which you are receiving care, and to any health-care agents you have named.

2. Post a copy of the form on the front of your refrigerator or another location where an emergency responder will easily see it.

3. You should talk to the person you have named as agent to make sure that he or she fully understands your wishes and is willing to take the necessary responsibility.

4. You have the right to revoke this advance health care directive or replace this form at any time.

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Glossary of Advance Health Care Directive Terms

Advance Health Care Directive: A general term describing two kinds of legal documents, an individual's instruction and a power of attorney for health care. These documents allow a person to give instructions about future medical care in case they are unable to participate in medical decisions due to serious illness or incapacity.

Agent is a person designated in a power of attorney for health care to make health-care decisions for the person granting the power.

Artificial nutrition and hydration: Supplying food and water through a conduit, such as a tube or an intravenous line where the recipient is not required to chew or swallow voluntarily, including, but not limited to, nasogastric tubes, gastrostomies, jejunostomies and intravenous infusions. Artificial nutrition and hydration does not include assisted feeding, such as spoon or bottle feeding.

Capacity: An individual's ability to understand the significant benefits, risks and alternatives to proposed health care and to make and communicate a health-care decision.

Health care: Any care, treatment, service or procedure to maintain, diagnose or otherwise affect an individual's physical or mental condition.

Health care decisions: A decision made by an individual or the individual's agent, guardian, or surrogate, regarding the individual's health care, which may include: a) Selection and discharge of health care providers and institutions; b) Approval or denial of diagnostic tests, surgical procedures, programs of medication and orders not to resuscitate; and c) Directions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care.

Health care institution: An institution, facility or agency licensed, certified or otherwise authorized or permitted by law to provide health care in the ordinary course of business.

Hospice: An institution or service that provides palliative care when medical treatment is no longer expected to cure the disease or prolong life.

Individual Instruction: An individual's wishes concerning a health-care decision for the individual.

Notary Public: A person who administers oaths, certifies documents, takes affidavits, and attests to the authenticity of signatures.

Physician: An individual authorized to practice medicine under the Wyoming Medical Practice Act.

Principal: The person who gives authority to an agent to make health-care decisions in the event that he or she becomes incapacitated. Also, the person for whom the advance health care directive has been created.

Power of Attorney for Health Care: The designation of an agent to make health-care decisions for the individual granting the power. This type of advance directive might also be called a health care proxy, or durable power of attorney for health care.

Health care provider: Any person licensed under the Wyoming statutes practicing within the scope of that license as a licensed physician, licensed physician's assistant or licensed advanced practice registered nurse.

Primary physician: A physician designated by an individual or the individual's agent, guardian or surrogate to have primary responsibility for the individual's health care or, in the absence of a designation, or if the designated physician is not reasonably available, a physician who undertakes the responsibility.

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PART 1: POWER OF ATTORNEY FOR HEALTH CARE

PLEASE NOTE: *Answering any of the following questions is optional, but the more information you provide on this form, the better your designated agent may act on your behalf. This form is not to be used to designate a financial power of attorney. It is for health care matters only. This form is in compliance with Wyoming State Statute 35-22-401 through 416.*

(1) **Designation of agent**: I designate the following person as my agent to make health care decisions for me:

_____
(name of person you choose as your agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone) (cell phone)

If I revoke my agent's authority, or if my agent is not willing, able or reasonably available to make a health-care decision for me, **I designate as my alternate agent:**

_____
(name of person you choose as your alternate agent)

_____
(address)

_____
(city) (state) (zip code)

_____
(home phone) (work phone) (cell phone)

(2) **Agent's authority:** My agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw artificial nutrition and hydration and all other forms of health care, except as I state here:

_____

_____

_____
(Add additional sheets if needed.)

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(3) When agent's authority becomes effective: My agent's authority to make health care decisions for me takes effect at the following time (**check and initial only one (1) option**):

Check Initial

☐ _____ If I check the box and initial, my agent's authority to make health care decisions for me becomes effective only when my primary physician or, in his/her absence, my treating primary health care provider determines that I lack the capacity to make my own health care decisions; OR

☐ _____ If I check the box and initial, my agent's authority to make health care decisions for me becomes effective only when my primary physician (and **not** when any then treating health care provider of mine) determines that I lack the capacity to make my own health care decisions; OR

☐ _____ If I check the box and initial, my agent's authority to make health care decisions for me becomes effective as necessary immediately upon my execution of this Advance Health Care Directive Form.

(4) **Agent's obligation:** My agent shall make health care decisions for me in accordance with this power of attorney for health care using any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent that my wishes are unknown, my agent shall make health-care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.

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PART 2: INSTRUCTIONS FOR HEALTH CARE

(5) End-of-Life decisions: I direct that those involved in my care provide, withhold or withdraw treatment in accordance with the choice I have checked and initialed below (check and initial only one option):

Check Initial

☐ _____ (a) **Choice to Prolong Life:** I want my life to be prolonged as long as possible within the limits of generally accepted health care standards.

OR

☐ _____ (b) **Choice Not to Prolong Life:** I do not want my life to be prolonged if:

(i) I have an incurable and irreversible condition that will result in my death within a relatively short time;

(ii) I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness;

(iii) The likely risks and burdens of treatment would outweigh the expected benefits.

(6) Artificial nutrition and hydration: Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in paragraph (5) unless I have checked and initialed **one** of the boxes below:

Check Initial

☐ _____ I **want** artificial nutrition regardless of my condition.

☐ _____ I **do NOT** want artificial nutrition regardless of my condition.

☐ _____ I **want** artificial hydration regardless of my condition.

☐ _____ I **do NOT** want artificial hydration regardless of my condition.

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(7) Relief from pain:

Check Initial

☐ _____ I want treatment for the alleviation of pain or discomfort at all times;

OR

☐ _____ I do NOT want treatment for the alleviation of pain or discomfort.

(8) **Other wishes:** (If you do not agree with the choices above, you may write your own or add to the instructions above. Examples may include: blood or blood products; chemotherapy; simple diagnostic tests; invasive diagnostic tests; minor surgery; major surgery; antibiotics; oxygen; wish to die at home if possible; etc.) I direct that:

_____
_____
_____
_____
_____
_____

PART 3: DONATION OF ORGANS AND TISSUES UPON DEATH

(9) Upon my death (check and initial applicable boxes):

Check Initial

☐ _____ (a) I have arranged to give my body to science.

☐ _____ (b) I have arranged through the Wyoming Donor Registry to give any needed organs and/or tissues (For enrollment information, call 1-888-868-4747 or visit WyomingDonorRegistry.org).

☐ _____ (c) I do NOT wish to donate my body, organs and/or tissues.

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PART 4: INFORMATION ABOUT MY HEALTH CARE PROVIDER

(10) The following physician is my primary physician:

_____
(name of physician)

_____
(address) (city) (state) (zip code)

_____
(phone)

More information about my health care can be obtained through:

_____
(name of health care institution/hospice)

_____
(address) (city) (state) (zip code)

_____
(phone)

(11) Effect of copy: A copy of this form has the same effect as the original.

SIGNATURE (Sign and date the form here):

_____
(print your name)

_____
(sign your name) (date)

_____
(address) (city) (state) (zip code)

_____
(phone)

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SIGNATURES OF WITNESSES or NOTARY PUBLIC:

I declare under penalty of perjury under the laws of Wyoming that the person who signed or acknowledged this document is known to me to be the principal, and that the principal signed or acknowledged this document in my presence.

Please Note: *Under Wyoming State Statute 35-22-403 (b), a witness may not be a treating health care provider, operator of a treating health care facility or an employee of a treating health care facility.*

First witness

_____
(print witness' name) (address)

_____
(signature of witness) (date)

Second witness

_____
(print witness' name) (address)

_____
(signature of witness) (date)

OR

Notary (in lieu of witnesses)

State of Wyoming

County of_____) SS.

Subscribed and sworn to and acknowledged before me by_____, the Principal, this

_____ day of _____, _____.

My commission expires: _____.

_____
Notary Public's Signature