

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;
- 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 healthcare directive or replace this form at any time.



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.

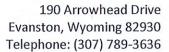
Health care decisions: A decision made by an individual or the individual's agent, guardian, or surrogate, regarding the individual's health care, which may include:

- 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
- 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 healthcare 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.





Glossary of Advance Health Care Directive Terms (Continued)

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

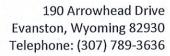
Physician: An individual authorized to practice medicine under the Wyoming Medical Practice Act.

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.

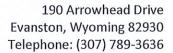
Health care provider: Any person licensed under the Wyoming statutes practicing within the scope of that license as a licensed physician, licensed physician's assistant or licensed advanced practice registered nurse.

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.





Print your full name:		
Today's date:	Initial that you have com	pleted the page:
PLEASE NOTE: Answering at this form, the better your design	: POWER OF ATTORNEY FOR Hand of the following questions is optional, but gnated agent may act on your behalf. This for for health care matters only. This form is in 6.	the more information you provide or orm is not to be used to designate a
(1) Designation of agent: I des	signate the following person as my agent to	make health care decisions for me:
(name of person you choose as y	our agent)	
(address)		
(city)	(state)	(zip code)
(home phone)	(work phone)	(cell phone)
decision for me, I designate a		ably available to make a nealth care
(address)		
(city)	(state)	(zip code)
(Oity)	(otato)	(210 0000)
(home phone)	(work phone)	(cell phone)
(2) Agent's authority: My ag	ent is authorized to make all health care	e decisions for me, including
	ld or withdraw artificial nutrition and hyd	
care, except as I state here:		
	- Y - Y - Y - Y - Y - Y - Y - Y - Y - Y	
(Add additional sheets if needed)		





(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.



Print your full name:		
Todav's date:	Initial that you have completed the page:	

Today's date:	Initial that you have completed the page:
	PART 2: INSTRUCTIONS FOR HEALTH CARE
	cisions: I direct that those involved in my care provide, withhold or withdraw dance with the choice I have checked and initialed below (check and initial only one
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.
	on and hydration: Artificial nutrition and hydration must be provided, withheld or rdance with the choice I have made in paragraph (5) unless I have checked and 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.

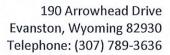


Print you	full name:
Today's	late: Initial that you have completed the page:
(T) D II (
(7) Relief	rom pain:
Check	Initial
	I want treatment for the alleviation of pain or discomfort at all times;
	OR
	I do NOT want treatment for the alleviation of pain or discomfort.
(8) Other	vishes: (If you do not agree with the choices above, you may write your own or add to the
instruction	s above. Examples may include: blood or blood products; chemotherapy; simple diagnost
tests; inva	sive diagnostic tests; minor surgery; major surgery; antibiotics; oxygen; wish to die at hom
if possible	; etc.) I direct that:
	PART 3: DONATION OF ORGANS AND TISSUES UPON DEATH
(9) Upon r	ny 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 (888) 868-4747 or visit http://www.donatelifewyoming.org
	(c) I do NOT wish to donate my body, organs and/or tissues.



Print your full name:	
Today's date:	Initial that you have completed the page:

roday 3 date.	midal that you hav	ve completed the page.	
PART 4: IN	FORMATION ABOUT MY HE	EALTH CARE PROVIDER	
(10) The following physicia	an 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 a	as the original.	
SIGNATURE (Sign and	date the form here):		
(print your name)			
(I)			
(sign your name)		(date)	
(address)			
(city)	(state)	(zip codo)	





First Witness

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.

(print witness' name)	(address)		
(signature of witness)		(date)	
Second Witness			
(print witness' name)	(address)		
(signature of witness)		(date)	
	OR		
Notary (in lieu of witnesses	s)		
State of Wyoming			
County of	}} ss.		
Subscribed and sworn to and acknowle	edged before me by		1
the Principal, this	_day of		
My commission expires:			