

The Basics of Advance Care Planning

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OBasic Terminology OImportant Documents



O Advance Care Planning

OThe process of discussing the type of care you would or would not want for yourself.

OPreferences such as the type of care you want, where you would want to pass away, who would make decisions for you.

OCreates a written record of your wishes, values, preferences, and decisions to ensure that care is delivered in the way you desire.



O Advance Directives

ODirectives that pertain to treatment preferences and the designation of a surrogate decision maker when you are no longer able to make decisions on your own behalf.

OThere are 3 categories of Advance Directives...



O<u>3 Categories of Advance Directives continued...</u>

O<u>1. Living Will</u>

OA written document intended to specify your medical wishes for when you are still living.

OLiving will can be very specific or general.

OIncludes decisions regarding prolonging life or withdrawing treatment; artificial nutrition and hydration as well as use of pain medication.



O 3 Categories of Advance Directives continued...

O2. Healthcare Proxy (Power of Attorney)

OThis person is designated to make health care decisions on your behalf.

OThis person knows what you want.



O 3 Categories of Advance Directives continued...

O<u>3. Durable Power of Attorney</u>

• A person who is designated to make healthcare and financial decisions on your behalf if you become incapacitated.

Important Documents



OAdvance Health Care Directive OPOLST



Advance Healthcare Directive

OAdvance Health Care Directive

OEveryone over 18 should have one.

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Last	First	Middle initial	Date of Bi	rth	Date
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Home Phone	Cell Phone	E-m	nil		
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Street Address		City	State	Zip	
Home Phone	Cell Phone	E.m	sil		
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	I have attached addition	nal sheet/s
My thoughts about when I would not want my life prolonged by n If I no longer have the mental capacity to make my own decisions if I can no longer safely swallow, etc):		
	I have attached addition	nal sheet/s

Print Your F	ull Name	Your Signature	Date of Bi	rth	Date
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HAWAI'I ADVANCE HEALTH CARE DIRECTIVE

My name is:

Last First Middle initial Date of Birth Date
PART 1: HEALTH CARE POWER OF ATTORNEY – DESIGNATION OF AGENT:

I designate the following individual as my agent to make health care decisions for me:

Name	and relationship of ir	dividual designated as	health care agent	
Street Address		City	State	Zip
Home Phone	Cell Phone	E	L-mail	

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent:

Name	and relationship of individual designated as health care agent					
Street Address		City		State	Zip	
Home Phone	Cell Phone		E-mail			

AGENT'S AUTHORITY AND OBLIGATION:

My healthcare agent should make decisions as I have instructed in Part 2 of this form or as I may otherwise provide orally or in writing. If there are decisions for which I have not provided instructions, I want my agent to make such decisions as I would have chosen to do, basing them on my values, goals, and preferences rather than those of my agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:

My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

- If I mark this box, my agent's authority to make health care decisions for me takes effect immediately. However, I always retain the right to make my own decisions about my health care. I can revoke this authority at any time as long as I have mental capacity.
- PART 2: INDIVIDUAL INSTRUCTIONS (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

A. END OF LIFE DECISIONS

- If I have an incurable and irreversible condition that will result in my death within a relatively short time, OR
- If I have lost the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability, OR
- If the likely risks and burdens of treatment would outweigh the expected benefits.

THEN I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: Check only one of the following boxes. You may also initial your selection.

- _ 🗌 I want to stop or withhold medical treatment that would prolong my life.
- OR
 - I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

Advance Healthcare Directive



OPart 1 ODesignation of Agent

HAWAI'I ADVANCE HEALTH CARE DIRECTIVE

My name is:

Last First Middle initial Date of Birth Date
PART 1: HEALTH CARE POWER OF ATTORNEY – DESIGNATION OF AGENT:

I designate the following individual as my agent to make health care decisions for me:

Name	and relationship of ir	dividual designated as	health care agent	
Street Address		City	State	Zip
Home Phone	Cell Phone	E	L-mail	

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AGENT'S AUTHORITY AND OBLIGATION:

My healthcare agent should make decisions as I have instructed in Part 2 of this form or as I may otherwise provide orally or in writing. If there are decisions for which I have not provided instructions, I want my agent to make such decisions as I would have chosen to do, basing them on my values, goals, and preferences rather than those of my agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

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- _ 🗌 I want to stop or withhold medical treatment that would prolong my life.
- OR
 - I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

Advance Healthcare Directive



OPart 2 OIndividual Instructions

YOUR NAME:

Print Your Full Name

Date of Birth Date

PART 2: INDIVIDUAL INSTRUCTIONS (CONTINUED) (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

B. ARTIFICIAL NUTRITION AND HYDRATION - FOOD AND FLUIDS:

Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in the preceding paragraph A unless I mark the following box.

_ If I mark this box, artificial nutrition and hydration must be provided under all circumstances as long as it is within the limits of generally accepted healthcare standards.

C. RELIEF FROM PAIN:

_ _ If I mark this box, I choose treatment to alleviate pain or discomfort even if it might hasten my death.

D. OTHER

_ If I mark this box, the additional instructions or information I have attached are to be incorporated into my care. (Sign and date each added page and attach to this form.)

E. WHAT IS IMPORTANT TO ME: (Optional. Add additional sheets if needed.) The things that I value and that make life worth living to me are: (examples: gardening, walking my pet, shopping, participating in family gatherings, attending church or temple):

I have attached _____ additional sheet/s

I have attached

additional sheet/s

My thoughts about when I would not want my life prolonged by medical treatment (examples include: If I no longer have the mental capacity to make my own decisions, if I have lost all ability to communicate, if I can no longer safely swallow, etc):

Advance Healthcare Directive



OPart 2 OIndividual Instructions continued...

Share and discuss your Advance Health Care Directive with your doctor, loved ones and agent Page 2 of 3

YOUR NAME: (Please sign in front of witnesses or notary public)

Print Your Full Name

Date of Birth

Date

WITNESSES: CHOOSE EITHER OPTION 1 OR 2, NOT BOTH.

Important: Witnesses cannot be your health care agent, a health care provider or an employee of a health care facility. One witness cannot be a relative or have inheritance rights.

Your Signature

OPTION 1: WITNESSES

I (Witness 1) declare that the person completing this advance health care directive is personally known to me, that she/ he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not related by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of her/his estate. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

Witness #1 Print Name	Witness Signature	Date
Street Address	City	State Zip

I (Witness 2) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

	Witness #2 Print Name	Witness Signatur	e Date
	Street Address	City	State Zip
OPTION 2	: NOTARY PUBLIC		
State of Haw (City and) Co	vaiʻi, ounty of] ss.	
On this	day of	, in the year(insert	, before me,
			ally known to me (or proved to me
on the basis	of satisfactory evidence) to be	the person whose name is sub-	scribed to thispage Hawai'i
Advance Hea	alth Care Directive dated on _	, in the	Judicial Circuit of
the State of I	Hawaiʻi, and acknowledged th	at he/she executed the same as	s his/her free act and deed.

Signature of Notary Public

My Commission Expires:_____

A copy has the same effect as the original. www.kokuamau.org/resources/advance-directives Developed by the Executive Office on Aging and Kōkua Mau - A Movement to Improve Care December 2015

Place Notary Seal or Stamp Above

Share and discuss your Advance Health Care Directive with your doctor, loved ones and agent Page 3 of 3

Advance Healthcare Directive



O Signatures





OProvider Order for Life Sustaining Treatment

OA medical order, signed by a medical professional.

OShould be completed when a person is seriously ill or has advanced frailty.

ROVIDER ORDERS FOR LIF	E-SUSTAI	NING TREAT	MENT (P	OLST) - HAWAI'I		P.0.	levt Name (last, first, middle)
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the patient has a pulse, then for	low orders i						capacity and no health care agent or cou
IEDICAL INTERVENTIONS:		** Person has	pulse and/	or is breathing **			agent or guardian or designated surroga mode reasonable efforts to locate as mo
Comfort Measures Only Use medi and suffering. Use oxygen, suction and mo needs connot be met in current location.	incal treatment	of airway obstructio	n as needed for	comfort. Trænsfer if confort	τ		lack of capacity and that a surrogate decision makes as the patient's surrogate decision makes and understand the limitations regardley
Limited Additional Interventions as indicated. Do not intubate. May use lee Transfer to hospital if indicated. Avoid int	a invasive airwae	escribed above. Use / support (e.g. contin	medical treatm nacus or bi-leve	ent, antibiotics, and IV fluids (positive airway pressure).	s		Signature (required)
Full Treatment includes care describe and defibriliation/cardioversion as indicat	ed above. Use int ed. Transfer to h	ubation, advanced a expitel (fireficated.)	inway intervent Includirs Internal	ions, mechanical ventilation, vr.com.	·	Ce	DIRECTIO mpleting POLST • Must be completed by health care profe
dditional Orders:							 POLST must be signed by a Physician or patient or the patient's legally authorize Use of original form is strongly encourse
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No artificial nutrition by tabe.		eriod of artificial nu	trition by tube.				 No delibrillator Uncluding automated ex
Long-term artificial nutrition by tube.	Goat						"Do Not Attempt Resuscitation."
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IGNATURES AND SUMMARY OF		NDITION DOWN	und with				be transferred to a setting able to provid • N medication to enhance comfort may b
Patient or Legaly Authorized Repres				e of the boxet below			. A person who desires IV fluids should ins
					1	5	ection C: • A patient or a legally authorized represe
Guardian Agent designated in Surrogate selected by consensus of intere			Patient-d	esignated surrogete a Minor			surrogate who has not been designated a decision to withhold or withdraw artifl physician certify in the patient's medical
gnature of Provider (Physician/APR)					4		prolonging the act of dying and the path
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evider Signature (required)		Provider License #				м	odifying and Voiding POLST
ignature of Patient or Legally Auth y signature below indicates that these order nown wishes and/ar in the best interests of t	s/resuscitative # he patient who i	reasures are consists	farm	hes or (if signed by LAR) the			 A person with capacity or, if lacking capa may revolve the POLST at any time and in To void or modify a POLST form, draw all all copies. Sign and date this line. Comp The addent's provider may methodile on
	Name (print)			(with set, a bapert)			status and goals of care.
remary of Medical Condition		Official Us	e Cely				Kök
							KBkue Meu is the lead agency for implor or find more POLST information KBkue Max + PD Rox 6217
SEND FORM WITH PERSO	ON WHENEVE	R TRANSFERRED	D OR DISCHA	RGED			SEND FORM WITH F

	HIPAA PERMITS DISCLOSURE OF POLS	T TO OTHER	HEALTH CARE PR	OFESSIONA	LS AS NECESSARY
	PROVIDER ORDERS FOR LIF	E-SUSTAI	NING TREATI	MENT (P	OLST) - HAWAI'I
	FIRST follow these orders. THEN		Patient's Last Name	•	-
	patient's provider. This Provider (based on the person's current me		First/Middle Name		
	and wishes. Any section not comp full treatment for that section. Eve				
	treated with dignity and respect.	eryone shan be	Date of Birth		Date Form Prepared
Α	CARDIOPULMONARY RESUSCITATI	ON (CPR):	** Person has	no pulse ai	nd is not breathing **
Check	Attempt Resuscitation/CPR	Do Not	Attempt Resuscit	ation/DNAR	(Allow Natural Death)
One	(Section B: Full Treatment required)				
	If the patient has a pulse, then foll	ow orders i			
B	MEDICAL INTERVENTIONS:				or is breathing **
Check One	Comfort Measures Only Use medic: and suffering. Use oxygen, suction and ma needs cannot be met in current location.				
	Limited Additional Interventions as indicated. Do not intubate. May use less <i>Transfer</i> to hospital if indicated. Avoid inte	invasive airway			
	Full Treatment Includes care described and defibrillation/cardioversion as indicated	d above. Use int			
	Additional Orders:				
С	ARTIFICIALLY ADMINISTERED NUT (See Directions on next page for information o			and liquid	by mouth if feasible and desired.
Check	No artificial nutrition by tube.		period of artificial nut	rition by tube.	
One	Long-term artificial nutrition by tube.	Goal:			
	Additional Orders:				
	SIGNATURES AND SUMMARY OF N	AEDICAL CO	DNDITION - Discus	sed with:	
D	Patient or Legally Authorized Represe	entative (LAR). I	f LAR is checked, you	must check on	e of the boxes below:
Check	Guardian Agent designated in	Power of Attorr	ney for Healthcare	Patient-d	esignated surrogate
One	Surrogate selected by consensus of interes	ted persons (Sig	gn section E)	Parent of	a Minor
	Signature of Provider (Physician/APRN	liconcod in t	ha stata of Hawai	 (;)	
	My signature below indicates to the best of my				e person's medical
	condition and preferences.				
	Print Provider Name		Provider Phone Numb	er	Date
	Provider Signature (required)		Provider License #		
	Signature of Patient or Legally Autho				
	My signature below indicates that these orders				hes or (if signed by LAR) the
	known wishes and/or in the best interests of th Signature (required)	e patient who is Name (print)	s the subject of this fo		(write 'self' if patient)
					,
	Summary of Medical Condition		Official Use	Only	
	SEND FORM WITH PERSO	N WHENEVE	R TRANSFERRED	OR DISCHA	RGED



OSection A:

OWhat to do if a person has no pulse and is not breathing

	HIPAA PERMITS DISCLOSURE OF POLST	TO OTHER	HEALTH	CARE PRO	FESSIONA	LS AS NECESSARY
	PROVIDER ORDERS FOR LIFE	-SUSTAI	NING [·]	TREATM	ENT (PC	DLST) - HAWAI'I
	FIRST follow these orders. THEN co		Patient's	s Last Name		-
	based on the person's current med	patient's provider. This Provider Order form is based on the person's current medical condition and wishes. Any section not completed implies		First/Middle Name		
	full treatment for that section. Even treated with dignity and respect.		Date of I	Birth		Date Form Prepared
Α	CARDIOPULMONARY RESUSCITATIO	ON (CPR):	** Pers	on has no	o pulse an	d is not breathing **
Check	Attempt Resuscitation/CPR (Section B: Full Treatment required)	Do Not	Attempt	Resuscitat	ion/DNAR	(Allow Natural Death)
One	If the patient has a pulse, then follo	ow orders	in B and	d C .		
D	MEDICAL INTERVENTIONS:				ulse and/o	or is breathing **
B Check One	Comfort Measures Only Use medica and suffering. Use oxygen, suction and man needs cannot be met in current location.					
	Limited Additional Interventions I as indicated. Do not intubate. May use less <i>Transfer</i> to hospital if indicated. Avoid inter	invasive airwa				
	Full Treatment Includes care described and defibrillation/cardioversion as indicated	above. Use int				
	Additional Orders:		, , ,			
С	ARTIFICIALLY ADMINISTERED NUTF (See Directions on next page for information or			fer food a	nd liquid l	by mouth if feasible and desired.
Check One	No artificial nutrition by tube.	Defined trial p Goal:	period of a	rtificial nutrit	ion by tube.	
	Additional Orders:					
	SIGNATURES AND SUMMARY OF M	IEDICAL CO	ONDITIC	DN - Discusse	d with:	
D	Patient or Legally Authorized Represe	ntative (LAR). I	f LAR is ch	ecked, you m	ust check one	e of the boxes below:
Check One	Guardian Agent designated in P	ower of Attor	ney for Hea	althcare	Patient-de	signated surrogate
	Surrogate selected by consensus of interest	ed persons (Si	gn section	E)	Parent of a	a Minor
	Signature of Provider (Physician/APRN I My signature below indicates to the best of my k condition and preferences.					person's medical
	Print Provider Name		Provider P	hone Number		Date
	Provider Signature (required)		Provider L	icense #		
	Signature of Patient or Legally Author My signature below indicates that these orders/	resuscitative r	neasures a	re consistent		es or (if signed by LAR) the
	known wishes and/or in the best interests of the Signature (required)	lame (print)	s the subje			(write 'self' if patient)
	Summary of Medical Condition			Official Use O	l nly	
	SEND FORM WITH PERSON		R TRAN	SFERRE <u>D</u> C	R DISCHA	RGED



OSection B:

OWhat to do if a person has a pulse and is breathing.

	HIPAA PERMITS DISCLOSURE OF POLST	TO OTHER	HEALTH CARE PRO	OFESSIONA	LS AS NECESSARY			
	PROVIDER ORDERS FOR LIFE	SUSTAI	NING TREATN	IENT (PC	DLST) - HAWAI'I			
	FIRST follow these orders. THEN col		Patient's Last Name					
	patient's provider. This Provider Ord based on the person's current medic and wishes. Any section not complet	dical condition leted implies	First/Middle Name					
	full treatment for that section. Every treated with dignity and respect.		Date of Birth		Date Form Prepared			
Α	CARDIOPULMONARY RESUSCITATION (CPR): ** Person has no pulse and is not breathing **							
Check	Attempt Resuscitation/CPR Do Not Attempt Resuscitation/DNAR (Allow Natural Death) (Section B: Full Treatment required)							
One	If the patient has a pulse, then follow orders in B and C .							
В	MEDICAL INTERVENTIONS:		** Person has p	ulse and/o	or is breathing **			
D Check One	Comfort Measures Only Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. <i>Transfer if comfort</i> <i>needs</i> cannot be met in current location.							
	Limited Additional Interventions Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). Transfer to hospital if indicated. Avoid intensive care.							
	Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. Transfer to hospital if indicated. Includes intensive care.							
	Additional Orders:							
С	ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and liquid by mouth if feasible (See Directions on next page for information on nutrition & hydration) and desired.							
Check	No artificial nutrition by tube.							
One	Goal:							
	Additional Orders:							
	SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:							
D	Patient or Legally Authorized Representative (LAR). If LAR is checked, you must check one of the boxes below:							
Check One	Guardian Agent designated in Power of Attorney for Healthcare Patient-designated surrogate							
One	Surrogate selected by consensus of interested persons (Sign section E)							
	Signature of Provider (Physician/APRN licensed in the state of Hawai'i.) My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.							
	Print Provider Name		Provider Phone Number		Date			
	Provider Signature (required)		Provider License #					
	Signature of Patient or Legally Authorized Representative My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the							
	known wishes and/or in the best interests of the patient who Signature (required) Name (print)		is the subject of this fo		lationship (write 'self' if patient)			
	Signature (required)			neiauonsnip	uonsnip (write sen in patient)			
	Summary of Medical Condition		Official Use	Dnly				
	SEND FORM WITH PERSON	WHENEV	ER TRANSFERRED	OR DISCHA	RGED			



OSection C: OArtificially administered nutrition

HIPAA PERMIT	S DISCLOSURE OF POLS	T TO OTHER	HEALTH	CARE PRO	FESSIONA	LS AS NECESSARY		
PROVIDE	R ORDERS FOR LIF	E-SUSTAI	NING	TREATM	ENT (PC	DLST) - HAWAI'I		
	RST follow these orders. THEN		Patient'	s Last Name				
ba	tient's provider. This Provider sed on the person's current me d wishes. Any section not comp	dical condition	First/Mi	ddle Name				
	I treatment for that section. Eve ated with dignity and respect.	eryone shall be	Date of	Birth		Date Form Prepared		
	MONARY RESUSCITAT	_			-	-		
haak -	Attempt Resuscitation/CPR Do Not Attempt Resuscitation/DNAR (Allow Natural Death) (Section B: Full Treatment required)							
	If the patient has a pulse, then follow orders in B and C .							
	TERVENTIONS:		** Pers	son has p	ulse and/o	or is breathing **		
heck and suffering	Comfort Measures Only Use medication by any route, positioning, wound care and other measures to relieve pain and suffering. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Transfer if comfort needs cannot be met in current location.							
as indicated.	Limited Additional Interventions Includes care described above. Use medical treatment, antibiotics, and IV fluids as indicated. Do not intubate. May use less invasive airway support (e.g. continuous or bi-level positive airway pressure). <i>Transfer</i> to hospital if indicated. Avoid intensive care.							
Full Treat	Full Treatment Includes care described above. Use intubation, advanced airway interventions, mechanical ventilation, and defibrillation/cardioversion as indicated. <i>Transfer to hospital if indicated. Includes intensive care.</i>							
	Additional Orders:							
neck No artificial	ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and liquid by mouth if feasible (See Directions on next page for information on nutrition & hydration) No artificial nutrition by tube. Long-term artificial nutrition by tube. Additional Octoor:							
	SIGNATURES AND SUMMARY OF MEDICAL CONDITION - Discussed with:							
Patient or								
heck Guardian	Guardian Agent designated in Power of Attorney for Healthcare Patient-designated surrogate							
One Surrogate se	Surrogate selected by consensus of interested persons (Sign section E)							
My signature bel	Signature of Provider (Physician/APRN licensed in the state of Hawai'i.) My signature below indicates to the best of my knowledge that these orders are consistent with the person's medical condition and preferences.							
	Print Provider Name		Provider Phone Number			Date		
Provider Signatur	Provider Signature (required)		Provider License #					
My signature bel	Signature of Patient or Legally Authorized Representative My signature below indicates that these orders/resuscitative measures are consistent with my wishes or (if signed by LAR) the							
	known wishes and/or in the best interests of the patient who Signature (required) Name (print)					nship (write 'self' if patient)		
	(print)							
Summary of Medi	cal Condition			Official Use O	nly			
SI	END FORM WITH PERSC	N WHENEVE	R TRAN	SFERRED	DR DISC <u>HA</u>	RGED		





O Signatures and Summary of Medical Condition

O Patient

O Guardian

- O Agent designated as POA
- O Patient designated surrogate
- O Surrogate selected by consensus of interested persons.

itient Name (last, first, middle)		Date of f	3irth	Gender M F
atient's Preferred Emergency Cont	tact or Legally Authorized	Representative	Phone Nu	umhar
ealth Care Professional Preparing Form	Preparer Title	Phone Number	Dat	te Form Prepared
SURROGATE SELECTED BY (Legally Authorized Represer I make this declaration under the p tative for the patient named on this capacity and no health care agent or agent or guardian or designated su made reasonable efforts to locate a lack of capacity and that a surrogat as the patient's surrogate decision- and understand the limitations rega Signature (required)	enalty of false swearing to esta s form. The patient has been de or court appointed guardian or rrogate is not reasonably availa as many interested persons as p e decision-maker should be sel maker in accordance with Haw	ablish my authority to act as the etermined by the primary phy patient-designated surrogate able. The primary physician or practicable and has informed lected for the patient. As a re- vai'i Revised Statutes §327E-5.	visician to lack of has been appo the physician' such persons of sult I have been I have read so	decisional ointed or the 's designee has of the patient's n selected to act ection C below on.
Signature (required)	Hame		Neidion	snip
 Section A: No defibrillator (including automat "Do Not Attempt Resuscitation." Section B: When comfort cannot be achieved be transferred to a setting able to p 	in the current setting, the pers provide comfort (e.g., treatmen	son, including someone with " nt of a hip fracture).	Comfort Meas	
 IV medication to enhance comfort i A person who desires IV fluids shou Section C: 			Aeasures Only	<i>"</i>
 A patient or a legally authorized rep surrogate who has not been design a decision to withhold or withdraw physician certify in the patient's me prolonging the act of dying and the 	nated by the patient (surrogate vartificial nutrition and hydratic edical records that the provision	selected by consensus of inte on when the primary physicia on or continuation of artificial	rested persons n and a second nutrition or hy	s) may only make d independent dration is merely
Reviewing POLST It is recommended that POLST be review • The person is transferred from one • There is a substantial change in the • The person's treatment preference:	care setting or care level to an person's health status, or			
 Modifying and Voiding POLST A person with capacity or, if lacking may revoke the POLST at any time : To void or modify a POLST form, dra all copies. Sign and date this line. C 	and in any manner that commu aw a line through Sections A th Complete a new POLST form inc	unicates an intention as to thi prough E and write "VOID" in I dicating the modifications.	s change. arge letters on	

i në patient s provider may status and goals of care.

Kōkua Mau - A Movement to Improve Care

Kōkua Mau is the lead agency for implementation of POLST in Hawai'i. Visit www.kokuamau.org/polst to download a copy or find more POLST information. This form has been adopted by the Department of Health July 2014 Kōkua Mau • PO Box 62155 • Honolulu HI 96839 • info@kokuamau.org • www.kokuamau.org

SEND FORM WITH PERSON WHENEVER TRANSFERRED OR DISCHARGED

OSection E:

OSurrogate selected by consensus of Interested Persons.

OLAR (Legally Authorized Representative as outlined in Section D.)





POLST

Key Takeaways and Discussion



O Everyone needs an Advance Healthcare Directive ONot Everyone needs a POLST.

O Download and Print blank copies at

Owww.islandshospice.com

OTalk to your doctor

• For additional education, call Islands Hospice and request our Transitional Care Program.

O550-2552

