PCS
PRIMARY CARE SPECIALISTS

110 Vista Drive
Pocatello, ID 83201

(208) 234-2300

Dear Patient,

Thank you for choosing Primary Care Specialists for your upcoming colonoscopy procedure. We want to make sure your procedure goes as smoothly as possible.

In this packet you will find:

1. **Advance preparation** about a colonoscopy, including what will happen on the day of your procedure

2. **Bowel prep information,** which begins several days before the procedure itself

3. Information on a **low-residue diet,** which you should begin three days before your procedure

4. Information on **where to report** for your colonoscopy

IMPORTANT: **Please read all of the information in this packet now!** This is important to be sure you take all the right steps to be prepared for your procedure. The steps include:

7 days before procedure	3 days before procedure	1 days before procedure	Day of procedure
Possible adjustments in your medications	Follow a low- residue diet and buy magnesium citrate prep	Stop solid foods, begin clear liquids, and take first dose of magnesium citrate	Take a second dose of magnesium citrate

If you have any questions about this information, please call us at (208) 234-2300.

Colonoscopy: advance preparation

This sheet provides general information about what will happen during and after your procedure, as well as special instructions for people with certain conditions.

IMPORTANT!

Please read this material as soon as you get it! **Preparations begin 7 days before your test.**

Special concerns

For some patients, special instructions may apply:

- **Diabetes** – Preparing for a colonoscopy involves some temporary changes in your diet. Please contact the doctor who manages your diabetes for advice regarding any changes that are needed in your diabetes medicine the day before and the day of your test. If you have an insulin pump, please discuss management with your diabetes doctor prior to your procedure.

- **Renal (kidney) failure** – If you have renal failure and have been advised to **severely** limit your intake of certain salts – such as sodium, magnesium, and phosphate – please talk with your own doctor about using the magnesium citrate prep discussed in this packet and find out if this is okay for you. Patients who are watching their salt intake as part of a treatment plan for high blood pressure or heart disease rarely have a problem with the magnesium citrate prep and do not need to take special precautions.

- The bowel prep can cause you to lose up to 2 quarts of fluid in the bowel movement. It is very important that you **drink extra fluid** on the day that you are completing your bowel prep and for 2 days after the examination. This helps avoid complications such as dizziness and fainting.

Arrange a ride home before the day of your test

It is extremely important that you make arrangements to **have a responsible adult available to take you home after your colonoscopy. The person must come and get you in the procedure area of the Endoscopy Suite when you are ready for discharge.** You **may not drive** yourself home after the test. This is a policy that is strictly enforced for your safety. **No exceptions are made unless you plan to undergo the procedure without sedation. If you wish to do this, you should discuss it with your doctor in advance.**

What happens during the procedure?

A colonoscopy is an effective and safe procedure that helps your doctor look for a variety of disorders of the large intestine.

When you arrive, a nurse will talk with you about your medical history, take your blood pressure and pulse, and place an intravenous (IV) line in your arm. The IV allows us to give you sedatives as needed during the procedure. Before the exam, a nurse will talk with you about the test, explain the risks and benefits, and ask you to sign a consent form. Although complications are rare, there is a small risk of problems such as bleeding, creation of a small tear or hole in the intestine, or inflammation of the vein used for IV medication.

Once you are in the procedure room, you will receive sedatives through the IV, which will make you feel drowsy. Your procedure will then begin. An instrument will be inserted into the rectum and moved into the colon. You may feel a sensation as if you have to move your bowels. This is normal and should not concern you. As the procedure is done, air is injected into the colon which may cause mild cramps or gas pains. However, the sedatives help you remain comfortable during the exam. Most patients report very little discomfort during colonoscopy. If you feel very uncomfortable or anxious, please speak up and more medication can usually be given. The doctor will examine your colon through the instrument, which projects images onto a screen. Once your colon has been completely checked, the doctor will remove the instrument and your test will be over. For most patients, colonoscopy takes about 30 minutes.

Going home

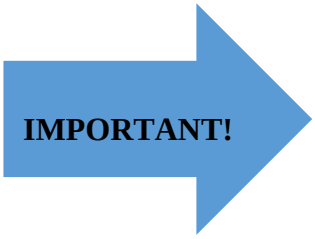
You will stay in our recovery area for about ½ hour after your procedure. A nurse will monitor your recovery and go over your discharge instructions with you. As noted above, you must not drive. You must be taken home by a responsible adult. Before you leave, be sure to ask any questions you have.

Recovering from sedation

Most patients receive sedatives for a colonoscopy. As you recover from the sedatives, you should not go back to work or school and you should not make important decisions. If you normally care for children or disabled relatives, get help with these responsibilities on the day of your test.

Bowel prep

This sheet contains important information about how to clean your bowels in preparation for your colonoscopy. **Please read all this information as soon as you get it** so you will know what preparations you need to make. **Your preparation for your colonoscopy begins 7 days before your test.** If you have any questions about preparing for your test, please call us at (208) 234-2300.



Please read this material as soon as you get it! **Preparations begin 7 days before your test.**

WHAT YOU WILL NEED

You will need to buy the following supplies for your prep. **Be sure you have them by the day before your colonoscopy.**

- Magnesium citrate, lemon or original flavor **– three (3) bottles** (10 oz. each) *** **(do not get cherry or grape flavor)**
- Three (3) bottles (16 oz. each) of clear liquid or sports drink (except red or pink)
- Packets of Jell-O – any color except red or pink
- Vegetable, chicken or beef bouillon broth cubes
- Baby Wipes

***Your magnesium citrate bottles may say not to take more than one bottle per day. For a colonoscopy prep, it is okay to take more as outlined in this sheet.

Medications

- Unless you are told otherwise, continue all medications. If you are taking insulin or other diabetes medicine, please contact the doctor who manages your diabetes for advice on how to manage your diabetes medicine in the days leading up to your procedure, when you will not be eating or drinking normally.
- If you are taking a blood thinner or anticoagulant – such as:
  - **Coumadin (warfarin)**
  - **Plavix (clopidogrel)**
  - **Pradaxa (dabigatran)**
  - **Lovenox (enoxaparin)**
  - **Arixta (fondaparinux)**
  - **Effient (prasugrel)**
  - **Brilinta (ticagrelor)**

  Call our office at (208) 234- 2300 for special instructions
- If you are taking **iron and/or an iron supplement,** please **stop taking it for 7 days before the procedure**.
- If you take aspirin, Motrin, or similar pain medicines, you may take them as usual. It is not necessary to stop taking these medicines before your colonoscopy.

Preparation

Three (3) days before your colonoscopy

- Begin a low-residue diet. (Example: If your test is on Tuesday morning, begin this diet on Saturday morning.) Avoid fruits, salads, cereals, bran, Metamucil, seeds, and nuts. For a detailed description of a low-residue diet, see enclosed fact sheet.
- Be sure you have purchased the materials listed in the box above.

The day before your colonoscopy

- Refrigerate your magnesium citrate bottles. It is better tolerated when cold

- Begin a clear liquid diet. Be sure to drink plenty of clear liquids throughout the day. You should be on a clear liquid diet all day, beginning at breakfast. Nothing solid. No milk or milk products. Clear liquids include: water; light-colored sodas; tea or coffee (black only); clear juices, such as white grape, apple, and cranberry (although cranberry juice is not clear, it is okay as long as it doesn't have any dye in it); chicken, beef, and vegetable broths; bouillon; Jell-O (no red Jell-O); and popsicles (no red popsicles). No hard candy or gum.

- **Between 3 and 7 pm - magnesium citrate dose #1**: At 7 pm the day before your procedure, drink 1 ½ bottles of
  Magnesium citrate (15oz.).

- Within the next 2 hours **drink at least three, 8-ounce glasses of clear liquids. It may take up to 6-8 hours before a bowel movement. When you begin to have diarrhea, baby wipes may be used to prevent irritation. Avoid using Vaseline jelly or Desitin.**

- **If you feel nauseated while doing the prep**, peppermint tea or sucking on a lemon may help. It also may help to put the magnesium citrate on ice.

The day of your procedure

- **6 hours before your scheduled procedure time – Take magnesium citrate dose #2:** Drink 1 ½ bottles of Magnesium citrate (15oz.). Note: Even though your stools may become clear after the first dose of magnesium citrate, you **must** take the full second dose. If you don't, your bowels may not be clean enough for the exam.

- Within the next 2 hours **drink at least three, 8-ounce glasses of clear liquids.**

- For those of you with a morning procedure, we realize it is inconvenient to wake up in the middle of the night to take the second dose of magnesium citrate. However, we have found this method results in the cleanest colon and the best chance for a successful examination.

- Arrive 30 minutes early for your appointment.

- Make sure to have a ride. You cannot drive home.

Low-residue diet for colonoscopy prep

Food group	Foods allowed…	Foods to avoid…
Milk and dairy	Milk and milk products. Includes: ▪ cow's milk ▪ ice cream ▪ yogurt ▪ cheese ▪ cream	▪ fruited yogurt ▪ any ice cream or cheese with nuts or seeds
Beverages	▪ coffee and tea ▪ carbonated beverages ▪ apple juice ▪ strained juice ▪ bottled water ▪ tomato juice ▪ fruit drinks without pulp, such as fruit punch ▪ Kool-Aid or Hi-C (without red dye) ▪ nutritional supplements without added fiber, such as Boost or Ensure	▪ any beverage containing pulp or seeds, such as orange or grapefruit juice ▪ prune juice ▪ nutritional supplements that contain fiber
Breads, cereals, and starches	▪ refined breads, rolls, bagels, English muffins, pita bread, biscuits, muffins, crackers, pancakes, waffles, or pastry ▪ refined cooked and cold cereals such as hominy grits, farina, cream of wheat or rice, strained oatmeal, Cheerios, Corn/Rice Chex, Cornflakes, Rice Krispies, Special K ▪ potato and sweet potato without skin ▪ white rice ▪ refined pasta	▪ whole grain breads, cereals, and pasta ▪ oatmeal ▪ granola ▪ any bread, cereal, cracker, or pasta made with seeds, nuts, coconut, or raw or dried fruit either on top or within product (such as bagels with seeds) ▪ corn bread ▪ graham crackers ▪ brown rice ▪ wheat germ ▪ bran ▪ sprouted wheat ▪ wild rice ▪ barley ▪ potato skins

Food group	Foods allowed…	Foods to avoid…
Fruits	▪ **canned or cooked** fruit without skins or seeds (peaches, pears, apricots, apples) ▪ applesauce ▪ ripe banana ▪ jellied cranberry sauce	▪ raw fruit (bananas are okay) ▪ canned pineapple, oranges, grapefruit sections, mixed fruit ▪ dried fruit ▪ all berries, melons ▪ whole cranberry sauce ▪ avocado ▪ coconut
Vegetables	▪ tender, well-cooked fresh, canned, and frozen vegetables without seeds such as peeled carrots, green beans, and beets ▪ strained vegetable juice ▪ strained tomato sauce	▪ **all raw vegetables**, such as lettuce, onion, celery, cucumber, mushrooms, scallions, etc. ▪ vegetables with seeds ▪ **tough, fibrous cooked vegetables** such as: artichokes, asparagus, broad beans, broccoli and cauliflower, brussel sprouts, celery, corn, cucumber, eggplant, mushrooms, onion, peas (green peas), sauerkraut and cabbage, spinach, tomatoes, zucchini summer squash, peppers, winter squash
Meat and meat substitutes	▪ cooked, tender fish, poultry, beef, lamb, pork, ham, veal, organ meats ▪ eggs ▪ cheese ▪ tofu ▪ tuna fish ▪ smooth peanut butter and other smooth nut butters	▪ non-tender meats ▪ gristle ▪ hot dogs ▪ salami, cold cuts ▪ meat substitutes made with whole grains, nuts, or seeds ▪ dried beans, peas, lentils ▪ crunchy-style peanut butter and other crunchy nut butters
Miscellaneous	▪ salt, sugar, ground or flaked herbs and spices ▪ vinegar ▪ ketchup and mustard ▪ soy sauce ▪ jelly (but not jam or preserves)	▪ pepper ▪ seed spices ▪ seeds and nuts ▪ coconut ▪ popcorn ▪ jams or preserves ▪ pickles and olives

Where to report for your colonoscopy

Please leave valuables at home when you come in for your test. Report to PCS Endoscopy Suite.

IMPORTANT!

Please read this material as soon as you get it! **Preparations begin 7 days before your test.**

Day/Date:	
Arrival Time:	
***Procedure Time:**	
Approximate discharge/pick up time:	
Doctor who will perform your procedure:	

**NOTE: Because medical procedures do not always go according to schedule, there may be unexpected delays in your procedure. We thank you in advance for your understanding.*

Insurance

Most insurance plans cover screening colonoscopies, however, we recommend that you check with your insurance before scheduling the procedure.

Cancelling or rescheduling your procedure

If you need to postpone your colonoscopy, **please call us at least 7 days in advance so that we may use that appointment for another patient.**

CONSENT FOR COLONOSCOPY WITH POLYPECTOMY AND/OR BIOPSIES

This consent form refers to risks and possible consequences, which may result. We are concerned mainly with perforation of the digestive tract and with hemorrhage. Perforation means to punch a hole in the colon. If this should occur, an immediate operation would probably be necessary. You would be put to sleep with a general anesthetic, your abdomen would be opened and the perforation would be closed. The risk of perforation is quite small, less than one in a thousand procedures. Hemorrhage means the occurrence of important bleeding following the procedure, as from biopsy sites or from injury occurring during passage of the instrument. In cases where bleeding has occurred, it has almost always stopped by itself. Rarely, blood transfusion has been required. In very rare cases, an operation has been necessary to control the bleeding. The risks of important hemorrhage are also quite small, less than one in several thousand procedures. Other rare but potential risks include an anaphylactic or allergic reaction, respiratory suppression, low oxygen, arrhythmia, myocardial infarction or pneumonia due to the sedatives used. A missed diagnosis must also be considered. When we consider the risks and possible complications of any manipulative procedure, we must also consider the extreme possibility of death occurring during or close to the time of the procedure. This is an extremely rare occurrence in connection with the procedure we are discussing. It is mentioned mainly for completeness so you may be fully informed when you sign your consent form. As you might imagine, we do not expect any of these events to happen during your procedure, but you must be aware of the possibilities.

As stated, please read our colonoscopy brochure prior to signing this consent. You are advised not to drive an automobile, operate mechanical equipment or engage in hazardous activity following the procedure because of the sedative effect of the medicines to be given. Have a responsible person read this brochure and consent, pick you up, drive you home and see that you are in responsible company for the rest of the day.

1. *I hereby authorize performance of the procedure called **COLONOSCOPY WITH POSSIBLE BIOPSIES AND/OR POLYPECTOMY** under the direction of Richard Maynard, D.O. and/or such assistants he may designate.*
2. *I have been made aware of certain risks and consequences that may be associated with the procedure described above.*
3. *It has been explained to me that during the course of the procedure, unforeseen conditions may be revealed that necessitate an extension of the original procedure and/or different procedure(s) than those set forth in this consent form. I therefore authorize and request that Richard Maynard, D.O. and his designated assistant(s) perform such procedure(s) as are necessary and desirable in the exercise of professional judgment, to include the administration of blood transfusion, should immediate need occur. The authorization granted under this paragraph shall extend to treating all conditions that require treatment and are not known to Richard Maynard, D.O. at the time the procedure commences.*
4. *I hereby consent to the administration of such anesthetics and or other medication as may be considered necessary or advisable by the physician responsible for this service.*
5. *I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantee has been made to me concerning the results of the procedures.*
6. *I also acknowledge I have been informed of alternatives to this procedure and understand those alternatives.*

*Patient Name*_____ *DOB* _____

Patient Signature _____

Date _____ *Time* _____

*Parent or Guardian Name (if patient is a minor)*_____

Parent or Guardian Signature _____

Date _____ *Time* _____ *Relationship* _____

Witness Signature _____

Form approved 8/6/2015

PCS Procedure Suite

(Procedures done in our procedure suite are not considered 'in office' procedures. When contacting your insurance for prior authorization, please let them know the procedure will be performed in an ambulatory surgery center and make sure that your insurance is in network with our ambulatory surgery center.)

Consent for admission and treatment at PCS Procedure Suite

Your physician has recommended you have a procedure, by signing this form you CONSENT TO and AUTHORIZE such procedure to be performed at PCS Procedure Suite. In addition, this consent covers any necessary anesthesia, pathology, laboratory procedures and emergency treatment, while inside PCS Procedure Suite.

The undersigned acknowledges and understands that no guarantee or assurance has been given as to the results which may be obtained.

Assignment of Insurance Benefits

In the event the patient is entitled to insurance benefits for the procedure being performed, said benefits are hereby assigned to PCS Procedure Suite. All disputes regarding coverage are between you and your insurance carrier. The undersigned and/or the patient shall assume all responsibility for charges not covered or deemed patient responsibility, by their insurance. If the undersigned does not have current insurance coverage, he/she accepts full responsibility for all charges incurred.

Release of Information

PCS Procedure Suite may disclose all or any part of the patient's records to any party that is or may be liable under a contract for all or part of PCS Procedure Suite charges. These may include: insurance companies, third party administrators, contract providers, or the patient's employer (in cases of worker's comp). Patient records will not be released to unauthorized individuals.

Financial Agreement

The undersigned, whether he/she signs as agent or as the patient, understands and agrees that upon admission to PCS Procedure Suite, the patient enters into a contract for payment of services rendered to him/her. This document constitutes a **BINDING CONTRACT** between the two parties. The undersigned agrees that in consideration of the services to be rendered to the patient, he/she hereby individually obligated himself/herself and if married obligates his/her marital partner, to pay the account of PCS Procedure Suite, Inc. in accordance with its regular terms and rates. PCS Procedure Suite will charge interest at a rate of 18% per year on any delinquent balances.

Statement to Permit Payment of Medicare to PCS Procedure Suite, Inc.

The undersigned requests payment of authorized Medicare Benefits to he/she on his/her behalf for any services furnished to the patient by or in PCS Procedure Suite. The undersigned authorizes PCS Procedure Suite to release to Medicare, CMS Administration or any of its intermediaries, carriers or agents, any information needed to determine these benefits or benefits for related services.

By signing below, I have read the information above and I choose to have my procedure performed at PCS Procedure Suite. I understand that Dr. Mansfield has ownership in PCS Procedure Suite, that PCS Procedure Suite is a separate entity from Primary Care Specialists. I will receive a bill from PCS for the doctor's service. I will receive a separate bill from PCS Procedure Suite, which covers the use of the facility, equipment, and supplies. I also understand that if I choose not to have my procedure done at PCS Procedure Suite, arrangements can be made at another facility, at my request.

THE UNDERSIGNED HAS READ, FULLY UNDERSTANDS, AND AGREES TO ALL OF THE ABOVE PROVISIONS AND INFORMATION IN THIS DOCUMENT.

_____ _____

Name (Print) / Date of Birth **DOB**

_____ _____

Signature: Patient/Parent or Legal Guardian **Legal Relationship to Patient**

_____ _____ _____

Date **Time** **Address**

_____ _____

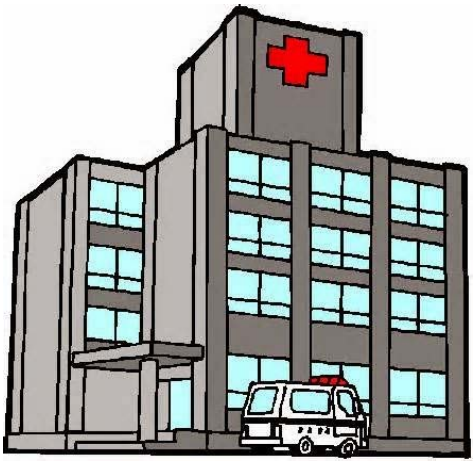
Home # & Work # **Witness**

Form approved 8/6/2015

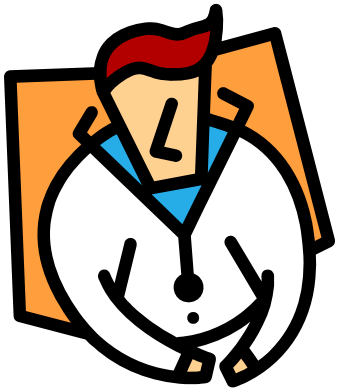
Billing for your Procedure

Total Cost of Your Procedure

2 Separate Bills



Medical Facility's Fee
PCS Procedure Suite



Physician Fee

The total cost for many medical services may be comprised of two fees. Each fee will be billed separately.

The medical facility fee (PCS Procedure Suite) covers the cost of the equipment and supplies involved in the performance of your service.

The physician's fee is for services provided by your physician or the actual procedure.

PCS ENDOSCOPY SUITE, INC.
Patient Rights and Responsibilities

Patient Rights

PCS Endoscopy Suite encourages respect for the personal preferences and values of each individual and supports the *Rights* of each patient of the Endoscopy Suite, or their designated representative as follows:

- The right to considerate and respectful care.
- The right to ask for and receive relevant, current, and understandable information concerning their diagnosis, treatment and prognosis from their physicians and other direct caregivers.
- The right to consent or refuse a treatment, as permitted by law, and in case of such refusal, the right to other appropriate care and services that the Endoscopy Suite provides or transfer to another facility.
- The right to have advance directives.
- The right to every consideration of privacy during consultation, examination and treatment.
- The right to expect all communications and records pertaining to medical care and to have the information explained or interpreted as necessary, except when restricted by law.
- The right to review their own records pertaining to medical care and to have the information explained or interpreted as necessary, except when restricted by law.
- The right to expect that, within its capacity and policies, the Endoscopy Suite will make a reasonable response to a request for appropriate and medically-indicated care and services, including evaluation, service and/or referral as indicated by the urgency of the case. If transfer is recommended and requested, the patient will be informed of risks, benefits, and alternatives, and will not be transferred until the other institution has indicted acceptance.
- The right to ask and be informed of the existence of business relationships among PCS Endoscopy Suite, educational institutions, other health care providers, or insurers that may influence the patient's treatment and care.
- The right to consent or decline to participate in research affecting care or requiring direct patient involvement, and if such participation is declined, to be entitled to the most effective care PCS Endoscopy Suite can otherwise provide.
- The right to be informed of realistic alternatives to care at PCS Endoscopy Suite.
- The right to be informed of PCS Endoscopy Suite policies and practices that relate to patient care and treatment, including charges for services and payment methods, and to be informed of available resources for resolving questions and concerns about care and treatment.

Patient Responsibilities

The collaborative measure of healthcare requires that patients participate in their care by fulfilling certain *Responsibilities*. Patients and/or families or designated representatives are responsible for:

- Requesting additional information or clarification about their health status or treatment when information or instructions are unclear.
- Ensuring that PCS Endoscopy Suite has a copy of their updated demographic information, should you need to be contacted.
- Informing physicians and other caregivers if there are problems in following prescribed treatment.
- Treating other patients, physicians, caregivers and staff with consideration and respect and recognizing that alternative care may be recommended if patient's, patient's representative or patient's family's behavior is considered unreasonably disruptive.
- Providing necessary information for insurance claims and for working with PCS Endoscopy Suite to make payment arrangements, when necessary.
- Show respect and consideration for meeting financial commitments.
- Recognizing the impact of their lifestyle on their personal health.
- Providing information about past illnesses, hospitalizations, medications, pertinent family history, and other matters related to health status.

You should expect to receive the highest quality of care at PCS Endoscopy Suite. Should you have any questions or concerns, please direct them to the facility manager on site. We appreciate constructive criticism and strive to improve our services whenever possible.

Complaint Resolution & Grievance Process

During your procedure, you and your family are encouraged to discuss questions about your care and the ASC environment with personnel and your physician. These individuals will assist in resolving issues or concerns.

If the patient or family member has a concern that is not promptly resolved after speaking with staff present, they may file a grievance. The grievance may be written or verbal and should be directed to:

Administration, PCS Endoscopy Suite
110 Vista Drive
Pocatello, ID 83201
208-234-0024 (#107)

A written response to each grievance will be provided to the patient or their representative within 14 days and will include the steps taken to investigate the grievance, the date the grievance process was completed and the name of an ASC contact person.

A patient or family also has the right to file a grievance with the following agency:

The Bureau of Facility Standards
3232 Elder Street
Boise, ID 83705
208-334-6626

You may also find support through a Medicare Ombudsman at the following website:
http://www.medicare.gov/navigation/help-and-support/ombudsman.aspx

Advance Directives

This Advance Directives packet contains a living will, which allows you to say what kind of medical treatment you will receive in the event that you are unable to let those wishes be known. The packet also contains a Durable Power of Attorney for Health Care, which allows you to appoint someone to make health care decisions for you if you are unable to do so.

INFORMATION YOU SHOULD KNOW BEFORE YOU COMPLETE YOUR LIVING WILL / DPA

1. A Living Will is a legal document, which allows you to choose whether you will receive artificial life-sustaining procedures or be allowed to die naturally, in the event that you have a terminal medical condition or you are in a persistent vegetative state.

2. The Living Will applies only to the question of continuing or discontinuing **artificial** life-sustaining procedures. IT IS NOT A 'DNR' (DO NOT RESUSCITATE) ORDER.

3. If you are interested in a DNR or a POST, please speak with your physician.

4. The Living Will goes into effect when a doctor* certifies that death is imminent and that the life=sustaining procedures would serve **only** to prolong artificially your life or that you are in a persistent vegetative state.

5. The phrase "administration of nutrition and hydration" refers to food and water provided by artificial means such as: through a feeding tube or an IV.

6. You may choose Box A, B, or C. Note: Box B has additional choices.

7. Express your wishes to your family, friends, lawyer, religious counselor, and primary physician so they know and understand what you want to have done. Give copies of the Advance Directives to those people, as well.

8. There is no time limit on the duration of Advance Directives. To revoke it you can destroy it or make a separate document revoking it. Health care providers will utilize the most current Advance Directive. All prior documents will be null and void.

*Effective July 1, 2007 Per HB119, no longer requires two (2) doctors.

LIVING WILL AND DURABLE POWER OF ATTORNEY FOR HEALTH CARE

Date of Directive	
Name of person executing Directive	
Address of person executing Directive	
DOB of person executing Directive	
SSN of person executing Directive	

A Living Will
A Directive to Withhold or to Provide Treatment

1. I willfully and voluntarily make known my desire that my life shall not be prolonged artificially under the circumstances set forth below. This Directive shall be effective only if I am unable to communicate my instructions and:
    a. I have an incurable or irreversible injury, disease, illness or condition, and a medical doctor who has examined me has certified:
        i. That such injury, disease, illness or condition is terminal; and
        ii. That the application of artificial life-sustaining procedures would serve only to prolong artificially my life; and
        iii. That my death is imminent, whether or not artificial life-sustaining procedures are utilized.

OR

    b. I have been diagnosed as being in a persistent vegetative state.

In such event, I direct that the following marked expression of my intent be followed and that I receive any medical treatment or care that may be required to keep me free of pain and distress.

Check ONE and initial:

Check	Initial

I direct that all medical treatment, care and procedures necessary to restore my health and sustain my life be provided to me. Nutrition and hydration, whether artificial or non-artificial, shall not be withheld or withdrawn from me if I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition.

OR

Check	Initial

I direct that all medical treatment, care and procedures, including artificial life-sustaining procedures, be withheld or withdrawn, except that nutrition and hydration, whether artificial or non-artificial shall not be withheld or withdrawn from if, as a result, I would likely die primarily from malnutrition or dehydration rather than from my injury, disease, illness or condition, as follows:

(*If none of the following are checked and initialed, then both nutrition and hydration, of any nature, whether artificial or non-artificial, shall be administered.)*

Check ONE and initial:

Check	Initial

A. Only hydration of any nature, whether artificial or non-artificial, shall be administered.

Check	Initial

B. Only nutrition, of any nature, whether artificial or non-artificial, shall be administered.

Check	Initial

C. Both nutrition and hydration, of any nature, whether artificial or non-artificial shall be administered.

OR

Check	Initial

I direct that all medical treatment, care and procedures be withheld or withdrawn, including withdrawal of the administration of artificial nutrition and hydration.

2. If I have been diagnosed as pregnant, this Directive shall have no force during the course of my pregnancy.

3. I understand the full importance of this Directive and am mentally competent to make this Directive. No participant in the making of this Directive or in its being carried into effect shall be held responsible in any way for complying with my directions.

4. Check ONE and initial:

Check	Initial

I have discussed these decisions with my physician and have also completed a Physician Orders for Scope or Treatment (POST) form that contains directions that may be more specific than, but are comparable with, this Directive. I hereby approve of those orders and incorporate them herein as if fully set forth.

OR

Check	Initial

I have not completed a Physician Orders for Scope of Treatment (POST) form. If a POST form is later signed by my physician, then this living will shall be deemed modified to be compatible with the terms of the POST form.

A Durable Power of Attorney for Health Care

1. DESIGNATION OF HEALTH CARE AGENT

None of the following may be designated as your agent:

- *Your treating health care provider*
- *A non-relative employee of your treating health care provider*
- *An operator of a community care facility; or*
- *A non-relative employee of an operator of a community care facility*

If the agent or an alternate agent designated in this Directive is your spouse, and your marriage is thereafter dissolved, such designation shall be thereupon revoked.

I do hereby designate and appoint the following individual as my attorney in fact (agent) to make health care decisions for me as authorized in this Directive.

Name of Health Care Agent	
Address of Health Care Agent	
Telephone Number of Health Care Agent	
Relationship of Health Care Agent to me	

For the purpose of this Directive, "health care decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose or treat an individual's physical condition.

2. CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTH CARE

By this portion of this Directive, I create a durable power of attorney for health care. This power of attorney shall not be affected by my subsequent incapacity. This power shall be effective only when I am unable to communicate rationally.

3. GENERAL STATEMENT OF AUTHORITY GRANTED

I hereby grant to my agent full power and authority to make health care decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make health care decisions that are consistent with my desires as stated in this Directive or otherwise made known to my agent including, but not limited to, my desires concerning obtaining or refusing or withdrawing artificial life-sustaining care, treatment, services and procedures, including such desires set forth in a living will, Physician Orders for Scope of Treatment (POST) form, or similar document executed by me, if any.

If you want to limit the authority of your agent to make health care decisions for you, you can state the limitations below in "Statement of Desires, Special Provisions, and Limitations", below.

4. STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS

(Your agent must make health care decisions that are consistent with your known desires. You can, but are not required to, state your desire in the space provided below. You should consider whether you want to include a statement of your desires concerning artificial life-sustaining care, treatment, services and procedures. You can also include a statement of your desires concerning other matters relating to your health care, including a list of one or more persons whom you designate to be able to receive medical information about you and/or to be allowed to visit you in a medical institution. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this Directive, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make health care decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this Durable Power of Attorney for Health Care, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated in my Physician Orders for Scope of Treatment (POST) form, a living will, or similar document executed by me, if any. Additional statement of desires, special provisions, and limitations are below:

_____

_____

_____

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_____

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_____

_____

(Attach additional pages or documents if you need more space to complete your statement.)

5. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH
    a. General Grant of Power and Authority

        Subject to any limitations in this Directive, my agent has the power and authority to do all of the following:

        1. Request, review and receive any information, verbal or written, regarding my physical or mental health including, but not limited to, medical and hospital records;
        2. Execute on my behalf any releases or other documents that may be required in order to obtain this information;
        3. Consent to the disclosure of this information; and
        4. Consent to the donation of any of my organs for medical purposes.

(*If you want to limit the authority of your agent to receive and disclose information relating to your health, your must state the limitations above in "Statements of Desires, Special Provisions and Limitations".)*

    b. HIPAA Release Authority

        My agent shall be treated as I would be with respect to my rights regarding the use and disclosure of my individually identifiable health information or other medical records. I authorize any physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, or other covered health care provider, any insurance company, and the Medical Information Bureau, Inc. or other health care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment form me for such services, to give, disclose and release to my agent without restriction, any past, present or future medical or mental health condition, including all information relating to the diagnosis of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse. The authority given my agent shall supersede any other agreement that I may have made with my health care providers to restrict access to or disclosure of my individually identifiable health information. The authority given my agent has no expiration date and shall expire only in the event that I revoke the authority in writing and deliver it to my health care provider.

6. SIGNING DOCUMENTS, WAIVERS, AND RELEASES

Where necessary to implement the health care decisions that my agent is authorized by this Directive to make, my agent has the power and authority to execute on my behalf all of the following:

a. Documents titled, or purporting to be, a 'Refusal to Permit Treatment' and/or a 'Leaving Hospital Against Medical Advice (AMA)' and
b. Any necessary waiver or release from liability required by a hospital or physician.

7. DESIGNATION OF ALTERNATE AGENTS

(You are not required to designate any alternate agents but you may do so. Any alternate agents you designate will be able to make the same health care decisions as the agent you designated in paragraph 1 above, in the event that your agent is unable or ineligible to act as your agent. If an alternate agent you designate is your spouse, he or she becomes ineligible to act as your agent if your marriage is thereafter dissolved.)

If the person designated as my agent in paragraph 1 is not available or becomes ineligible to act as my agent to make a health care decision for me or loses the mental capacity to make health care decisions for me, or if I revoke that person's appointment or authority to act as my agent to make health care decisions for me, then I designate and appoint the following persons to serve as my agent to make health care decisions for me as authorized in this Directive, such persons to serve are listed below:

A. First Alternate Agent

Name	
Address	
Telephone Number	
Relationship	

B. Second Alternate Agent

Name	
Address	
Telephone Number	
Relationship	

C. Third Alternate Agent

Name	
Address	
Telephone Number	
Relationship	

8. PRIOR DESIGNATIONS REVOKED

I revoke any prior Durable Power of Attorney for Health Care.

_____ _____

SIGNATURE OF PRINCIPAL *DATE*

9. AUTHORITY

(You must sign and date this Living Will and Durable Power of Attorney for Health Care.)

SIGNATURE OF PRINCIPAL

I sign my name to this Living Will and Durable Power of Attorney for Health Care on the date set forth at the beginning of this form:

_____ _____

SIGNATURE OF PRINCIPAL DATE

_____

WITNESS (ES)

Your Rights as a Patient to Make Medical Treatment Decisions

WHO DECIDES ON THE MEDICAL TREATMENT I RECEIVE IF I HAVEN'T MADE A LIVING WILL OR NAMED A PERSON TO CARRY OUT 'DURABLE POWER OF ATTORNEY FOR HEALTH CARE'?

Family members, with your doctor and other care givers or counselors will usually decide what is best for you; if you are too ill to decide. Most of the time this works. Sometimes, everyone doesn't agree about what to do. It is helpful to let everyone know what you want and whom you want your doctor to listen to. Treatment decisions can be hard to make. It will help your family and doctor if they know in advance what you want. You can let your family and doctor know your wishes by writing an Advance Directive to include a Living Will and/or A Durable Power of Attorney.

I _____(print name) have received the information on the previous pages and above and I understand my rights to make, or not to make a Living Will and a Durable Power of Attorney for Health Care.

	YES	NO
I have an Advance Directive:		
I have presented a copy of my Advance Directive to the facility staff today:		
I DESIRE to make an Advance Directive today:		
I have been given the paperwork to complete my Advance Directive and understand that if I need assistance that I can ask the Registered Nurse on staff at any time.		

_____ _____

Patient / Representative Signature Date

(If Representative, list name and relationship to patient and reason patient is unable to sign below)

_____

Representative Name

_____

Relationship

_____

Reason Patient is Unable to Sign.