Arizona
Healthcare Directives

This form lets you have a say about how you want to be cared for if you cannot speak for yourself.

This form has 3 parts:

Part 1

Make your own healthcare decisions, Page 3

This medical living will let you choose the kind of healthcare you want in case you cannot speak for yourself. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

Part 2

Choose your medical decision maker, Page 7

A medical decision maker is a person who can make healthcare decisions for you if you are not able to make them yourself.

This person is also called a *healthcare decision maker, agent* or *proxy*.

Part 3

Sign the form, Page 9

The form must be signed before it can be used.

You can fill out Part 1, Part 2, or both.

Fill out only the parts you want. However, you must sign the form in Part 3 and one witness must sign on Page 10, or a notary on Page 11.

This is a legal form that helps you have a voice in your healthcare.
It will help your family, friends, and medical providers know how you want to be cared for if you cannot speak for yourself.

Thoughtful Life Conversations
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What should I do with this form?

- Share this completed form with your medical decision maker, family, friends, and medical providers.
- Make sure copies of this form are placed in your medical record at all the places you receive medical care.

What if I have questions about the form?

- It is OK to skip any part of this form if you have questions or do not want to answer.
- Ask your medical providers, family, or friends to help.
- Contact a lawyer if you need legal advice.

What if I want to make healthcare decisions that are not on this form?

- On Page 5, you can write down anything else that is important to you.
- If you want to complete a Do Not Resuscitate Order (DNR or Prehospital Medical Care Directive), ask to talk to your medical provider about the orange form.
- If you want to complete an Arizona Provider Order for Life-Sustaining Treatment (AzPOLST), ask to talk to your medical provider about the pink form.

When should I review and update this form?

- If you change your mind about your healthcare decisions.
- If your health changes.
- If you want to remove or change your medical decision maker.
- If you have other important life changes such as marriage, divorce or death of medical decision maker.

Give the new form to your medical decision maker and medical providers.
Destroy old forms.

Share this form with your medical decision maker, family, friends and medical providers.

Part 1 Make your own healthcare decisions

This medical living will let you choose the kind of healthcare you want in case you cannot speak for yourself. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

"Quality of Life" differs for each person.

For some people, the main goal may be to be kept alive as long as possible even if they have to be kept alive on machines or they are too sick to talk to their family and friends.

For other people, the main goal may be to focus on quality of life and being comfortable. These people may prefer a natural death, and not be kept alive on machines.

Other people are somewhere in between. What is important to you?

Your goals may differ today in your current health from those at the end of life.

TODAY, IN YOUR CURRENT HEALTH

Put an X along this line to show how you feel today, in your current health.

My main goal is to live as long as possible, no matter what

Equally Important

My main goal is to focus on quality of life and being comfortable.

AT THE END OF LIFE

Put an X along this line to show how you would feel if you were so sick that you may die soon.

My main goal is to live as long as possible, no matter what

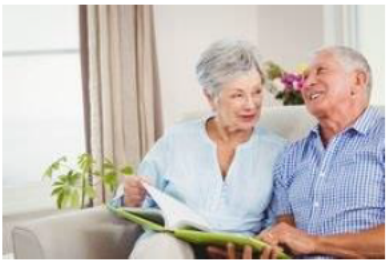
Equally Important

My main goal is to focus on quality of life and being comfortable.

What Matters Most in Life: Quality of life differs for each person. What is important to you?

You want your medical provider to try treatments that may get you back to an acceptable quality of life. However, if your quality of life becomes unacceptable to you and your condition will not improve (is irreversible), you may choose to have treatments that extend life to be withdrawn.

At the end of life, which of these things would make you want to focus on comfort rather than trying to live as long as possible?



- ☐ Being in a long-term coma and not able to wake up
- ☐ Not being able to live without being hooked up to machines
- ☐ Not being able to think for myself, such as dementia
- ☐ Not being able to tell others what I need
- ☐ Not being able to feed, bathe, or take care of myself
- ☐ Not being able to live on my own
- ☐ Having constant, severe pain or discomfort
- ☐ Something else_____

OR

- ☐ I am willing to live through all of these things for a chance to live longer.

How Do You Balance Quality of Life with Medical Care?

Please read this whole page before making a choice.

Sometimes illness and the treatments used to try to help people live longer can cause pain, side effects, and the inability to care for yourself.

AT THE END OF LIFE, some people are willing to live through a lot for a chance of living longer. Other people feel that certain things would be very hard on their quality of life.

Life support treatment can be Cardiopulmonary Resuscitation (CPR), a breathing machine, feeding tubes, dialysis, IV fluids, antibiotics, or transfusions.

If you were so sick that you could die soon, which would you prefer? (Initial A, B or C)

A. _____ I want ALL life support treatments that my medical providers think might help to extend my life.

B. _____ I want my medical providers to try life support treatments that they think might help, **except** the following treatments (check all that you do **NOT** want):

CPR	No ☐
Breathing Machine	No ☐
Feeding Tubes	No ☐
IV Fluids (Water by mouth is always offered)	No ☐
Dialysis	No ☐
Antibiotics	No ☐
Blood Transfusions	No ☐

C. _____ I DO NOT want life support treatments, and I want to focus on being comfortable. I want to have a natural death.

Is there anything else that your medical providers and medical decision maker should know about your choice? (you may attach another page)

_____

_____

I have attached a Do Not Resuscitate Order (DNR or Prehospital Medical Care Directive). ☐ **Yes** ☐ **No**

I have attached an Arizona Provider Order for Life-Sustaining Treatment (AzPOLST) Form. ☐ **Yes** ☐ **No**

Is religion or spirituality important to you? ☐ **Yes** ☐ **No**

If you have one, what is your religion?_____

What should your medical providers and medical decision maker know about your religious or spiritual beliefs?

_____

_____

Organ Donation

Your medical decision maker may be asked about organ donation after you die. Please tell us your wishes. If you do not complete this section, your decision maker may choose to donate your organs after your death.

The decision to be an organ, tissue and eye donor is yours. What do you prefer?

☐ Yes, I **want** to donate.
Which organs or tissue do you want to donate?
- ☐ Any organ, tissue, and eye
- ☐ Only_____

☐ No, I **do not** want to donate my organs, tissue, or eyes.

What else should your medical providers and medical decision maker know about donating your organs, tissue, or eyes?

_____

_____

There is no age limit or health requirements for organ donation.
Visit www.DonateLifeAZ.org for more information and to register as an organ, tissue and eye donor.

Part 2 Choose your medical decision maker

This Medical Decision Maker Form lets you choose a person to make healthcare decisions for you if you become too ill to communicate or you cannot make those decisions yourself.

A medical decision maker must be at least 18 years of age and should be someone who knows your wishes and values and who you trust to carry out your wishes. It may be a family member or friend.

What will happen if I do not choose a medical decision maker?

If you are not able to make your own decisions, a person will be chosen for you according to Arizona law. This person may or may not know what you want.

By signing this form, you give your medical decision maker full power to make healthcare decisions for you, including to:

- Choose your medical providers, caregivers, treatment options, and where you receive care;
- Agree to refuse or withdraw any life support or medical treatment. If you have completed a medical living will, your medical decision maker must follow your wishes; and
- Decide what happens to your body after you die, such as funeral or disposition arrangements and organ donation, if you have not made other arrangements.

Write the name of your medical decision maker.

I want this person to make my medical decisions if I am not able to make my own:

First Name _____ Last Name _____

Phone _____ Relationship _____ Email Address _____

Address: _____

If the first person cannot do it or refuses to do it, then I want this person to make my medical decisions:

First Name _____ Last Name _____

Phone _____ Relationship _____ Email Address _____

Address: _____

Mental Healthcare Decision Maker

This section must be initialed in front of a witness or a notary.

____ Initial here, to allow your medical decision maker the power to make mental healthcare decisions for you (mental health power of attorney).

____ Initial here, to allow your medical decision maker the power to admit you to an inpatient or partial psychiatric hospitalization program.

If there are mental health decisions you do not want them to make, write them here:

_____

This section may not be revoked if you are not able to make decisions for yourself, as determined by your physician.

Part 3 Sign the Form

This is a legal document. By signing it, you acknowledge that you carefully reviewed it and that the information reflects your wishes regarding who can make medical decisions for you, what those decisions should be, and that those wishes should be honored.

Before this form can be used, you must:

- Be at least 18 years of age
- Have one witness or a notary watch you sign this form

Sign your name and write the date.

_____ _____

Sign Your Name Today's Date

_____ _____ _____

Print Your First Name Print Your Last Name Date of Birth

Address:_____

Witness or Notary

Before this form can be used, you must have one witness sign the form or have it notarized. The job of a notary is to make sure it is you signing the form. The witness or notary must confirm the if the mental healthcare decision maker is initialed on page 8.

Witness

Have your witness sign his or her name and write the date.

By signing below, I promise that that the person named in part 3 on page 8 of this document, signed this form while I watched.

The person seemed to be of sound mind and free from duress, fraud, or undue influence.

I also promise that:

- I am at least 18 years of age
- I am not their medical decision maker
- I am not directly involved with the provision of healthcare
- I am not related to them by blood, marriage, or adoption
- I am not going to get any part of the person's estate (such as money or property) after he/she dies

_____ _____

Witness Signature Date

_____ _____

Print Witness First Name Print Witness Last Name

Witness Address: _____

If you do not have a witness, a notary must sign on Page 10.

Notary

Notary Public: Take this form to a notary public ONLY if one witness has not signed this form. Bring photo ID (driver's license, passport, etc.) ***[Notary must confirm if mental healthcare decision maker is initialed on page 8.]***

State of Arizona)
)
County of _____)

On this _____ day of _____, 20____, before me personally appeared _____ whose identity was proven and he or she appeared to be of sound mind and free from duress, fraud or undue influence and he or she signed the above document.

_____
NOTARY PUBLIC

[Affix Seal Here]

Congratulations!
You have completed your Arizona Healthcare Directives!

Share this form with your medical decision maker, family, friends, and medical providers. Talk with them about your medical decisions.

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Arizona
Prehospital Medical Care Directive (Do Not Resuscitate)

This form tells emergency medical technicians (EMTs) and/or hospital emergency room providers that you do not want CPR.

A Prehospital Medical Care Directive (Do Not Resuscitate) is a form signed by you and your medical provider if you make the decision you do not want CPR should your heart or breathing stop.

You may want to talk to your medical provider about this form if you are very ill, weak, and not expected to get better. If you decide to complete this form, EMTs and hospital emergency room providers will not use equipment, drugs, or CPR to start your heart or breathing. They will provide care to make you comfortable.

If you are healthy you may not wish to complete this form.

Must Do:

- **This form must be signed by both your medical provider and you**.
- **This form must be on bright orange paper.**
- **Put this form on your refrigerator door so EMTs will see it in case of an emergency and give a copy to your hospital, if you have one.**

THIS FORM MUST BE PRINTED ON BRIGHT ORANGE PAPER!

Share this form with your medical decision maker, family, friends and medical providers.
Talk with them about your medical decisions.

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PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE)

(IMPORTANT—THIS DOCUMENT MUST BE ON PAPER WITH ORANGE BACKGROUND)

GENERAL INFORMATION AND INSTRUCTIONS: A Prehospital Medical Care Directive is a document signed by you and your doctor that informs emergency medical technicians (EMTs) or hospital emergency personnel not to resuscitate you. Sometimes this is called a DNR – Do Not Resuscitate. If you have this form, EMTs and other emergency personnel will not use equipment, drugs, or devices to restart your heart or breathing, but they will not withhold medical interventions that are necessary to provide comfort care or to alleviate pain. **IMPORTANT**: Under Arizona law a Prehospital Medical Care Directive or DNR must be on letter sized paper or wallet sized paper on an orange background to be valid.

You can either attach a picture to this form, or complete the personal information. You must also complete the form and sign it in front of a witness. Your health care provider and your witness must sign this form.

1. My Directive and My Signature:

In the event of cardiac or respiratory arrest, I refuse any resuscitation measures including cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.

Patient Signature:_____ Date: _____

Patient's Printed Name: _____

PROVIDE THE FOLLOWING INFORMATION: **OR**

My Date of Birth
My Sex
My Race
My Eye Color
My Hair Color

ATTACH RECENT PHOTOGRAPH HERE:

2. Information About My Doctor and Hospice (if I am in Hospice)**:**

Physician:_____ Telephone:_____

Hospice Program, if applicable (name):_____

PREHOSPITAL MEDICAL CARE DIRECTIVE (DO NOT RESUSCITATE) (Last Page)

3. Signature of Doctor or Other Health Care Provider:

I have explained this form and its consequences to the signer and obtained assurance that the signer understands that death may result from any refused care listed above.

Signature of a Licensed Health Care Provider:_____ Date: _____

4. Signature of Witness to My Directive:

NOTE: At least one adult witness OR a Notary Public must witness the signing of this document. The witness or Notary Public CANNOT be anyone who is: (a) under the age of 18; (b) related to you by blood, adoption, or marriage; (c) entitled to any part of your estate; (d) appointed as your representative; or (e) involved in providing your health care at the time this form is signed.

I was present when this form was signed (or marked). The patient then appeared to be of sound mind and free from duress.

Signature:_____ Date:_____