We make plans for many things over the course of our life. One of the more difficult things to think about and plan for is our future medical care, especially the kind of care we would want at the end of our life. As difficult as it may seem, it is one of the most important health care decisions you will make.

First, think about the following questions about yourself: Do you have any significant health problems now? What kind of things give you such joy that, should a health problem prevent you from doing them anymore, life would have little meaning? What short or long-term goals do you have? How might medical treatment help you or hinder you in realizing these goals? What would it mean for you to live well even if your health failed? How would health decisions be made if you could not make them?

One of the most vital things you should consider is who would make medical decisions for you if you could not make them for yourself. If you were unconscious or just too ill to communicate your wishes, whom would you want to speak to the doctor for you? In Indiana this person is called your **Health Care Representative**, and he or she would have the authority to consent to treatment or refuse treatment based on what he or she knows about your wishes. The person you appoint should be someone that you trust to carry out your wishes and who would hold up well under stressful situations. This person cannot be a witness to the signing of that document. Please be sure to talk to your health care representative about the kind of health care you wish to receive.

Under Indiana law you also have the right to refuse life-prolonging treatments such as CPR, mechanical ventilator (breathing machine), and "artificial nutrition and hydration" (food and water supplied to you mechanically through I.V's and tubes). One of the ways you can make your wishes known is through a **Living Will Declaration**. This form is most helpful should you later develop a terminal or incurable disease or injury. Note that you are asked select a single choice among three options regarding artificial nutrition and hydration. Read the three options carefully. Your Living Will must be signed in the presence of two witnesses who are not immediate family. Neither form needs to be notarized.

After you complete the advance directives, we would also encourage you to make some additional copies. Send one copy to the Medical Records Department of the hospital(s) of your choice. Additional copies may be sent to your doctor as well as close family members or friends. Be sure to keep the originals for yourself.

Finally, put the original forms back in the CLEAR POCKET and place them in your kitchen refrigerator or freezer. Why the refrigerator? Because it is fire proof, most everybody has one, and it will be the place where emergency personnel will look if they are called to your home. When appropriate, you may put a sign on your freezer door saying, **ATTENTION PARAMEDICS: ADVANCE DIRECTIVES INSIDE**.

Please note that other instructions may be needed to limit the actions of emergency personnel called to your home. An Indiana **Physician's Order for Scope of Treatment** (IN-POST) form may be obtained by calling (812) 353-9262. The POST form should be filled out in the presence of and be signed by your doctor.

If you have any questions that are not addressed here please call the **Advance Directive Hotline** – (812) 353-9262.

Bloomington Hospital

Patient Identification Area
(label, cardoplate, etc.)

LIVING WILL DECLARATION

Declaration made this _______ day of ____________________ *(month,year)*.

I, ____ being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below, and I declare:

If at any time my attending physician certifies in writing that: (1) I have an incurable injury, disease, or illness; (2) my death will occur within a short time; and (3) the use of life-prolonging procedures would serve only to artificially prolong the dying process, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the performance or provision of any medical procedure or medication necessary to provide me with comfort care or to alleviate pain, and, if I have so indicated below, the provision of artificially supplied nutrition and hydration. *(Indicate your choice by initialing or making your mark before signing this declaration):*

☐ I wish to receive artificially supplied nutrition and hydration, even if the effort to sustain life is futile or excessively burdensome to me.

☐ I do not wish to receive artificially supplied nutrition and hydration, if the effort to sustain life is futile or excessively burdensome to me.

☐ I intentionally make no decision concerning artificially supplied nutrition and hydration, leaving the decision to my health care representative appointed under IC 16-36-1-7 or my attorney in fact with health care powers under IC 30-5-5.

In the absence of my ability to give directions regarding the use of life-prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences of the refusal.

I understand the full import of this declaration.

Signed	Date of Birth (Required)	Date	Time
City, County, and State of Residence			

The declarant has been personally known to me and I believe (him/her) to be of sound mind. I did not sign the declarant's signature above for or at the direction of the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Witness	Date	Time

Witness	Date	Time

Bloomington Hospital

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Appointment of Healthcare Representative

Patient Name

Pursuant to Indiana Code 16-8-12 et seq. I hereby appoint:

Name	Relationship to Patient (relative, friend, etc.)
Address	
Home Telephone Number	Work Telephone Number

as my representative to act in my behalf on all matters concerning my health care, including but not limited to providing consent or refusing to provide consent to medical care, surgery, and/or placement in health care facilities, including extended care facilities. This appointment shall become effective at such time and from time to time as my attending physician determines that I am incapable of consenting to my health care.

I hereby give the following instructions to my representative (*optional*):

1. ____
____
____
2. ____
____
____

I authorize all health care providers to rely upon consents and authorizations provided by my representative, and I ratify all that my representative shall do by virtue of this appointment. I agree to be financially responsible for health care services performed in reliance upon consents executed by my health care representative.

Patient Signature	Date	Time

Witness (Adult other than Representative)	Date	Time