# How to start the conversation about Advance Care Planning

Visit **ochsnerlsuhs.org/advanced-directives** for more information about our program.

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Ochsner | LSU Health SHREVEPORT

# Completing Advance Directive Documents

Any person age 18 or older who can make his or her own decisions can complete an advance directive. Forms are easy to complete, and we are here to help you.

**You do not need a lawyer to complete our forms. However, the forms need to be:**

- Dated.
- Signed by the patient or healthcare representative.
- Signed by two witnesses not related to the patient by blood or marriage and not entitled to any portion of the patient's estate.

It is important to review your forms every year to make sure they still reflect your wishes. You may cancel or revoke documents on file with Ochsner LSU Health Shreveport at any time verbally or in writing.

Copies should be given to your doctor and others you want to know of your wishes. If you should go to the hospital, bring a copy of your documents if not already on file. Keep your original documents in a location that is easy to find.

Visit **PrepareForYourCare.org** or **theconversationproject.org** to learn more. These websites are designed to make medical decision-making easier for patients and caregivers.

If you would like your advanced directive documents to be added to your medical chart, email **OLHS-HIM@ochsnerlsuhs.org** or upload through your MyChart account at my.ochsner.org/lsu

# How to start the conversation about Advance Care Planning

It is never too early to think about what is most important to you should your health change. While it can be hard to think about a time when you are sick or unable to make decisions for yourself, the earlier you plan, the better chance we have of giving you the medical care that is right for you.

At Ochsner LSU Health Shreveport, we want your voice to be heard and your wishes respected, no matter your medical condition.

Maybe you have had experiences with people close to you who have been sick. Have you visited loved ones in the ICU or hospital? Perhaps you have watched people get sick on TV or in movies. Reflecting on these situations can be a good first step in the process of advance care planning.

**Here are some ways to begin a discussion about this topic with a loved one:**

- "This is not easy to talk about. If I get sick or have an accident and cannot make medical decisions on my own, I want to tell you what is important to me, so you can be my decision-maker."
- "I need to think about the future. Will you help me?"
- "Even though I am okay right now, I am worried what would happen if something happens to my health. I would like to be prepared."

Follow the next steps to ensure your Ochsner LSU Health Shreveport healthcare team understands as much as possible about your values, your preferences and the people to turn to if you become sick.

## Step 1: Choose a Healthcare Power of Attorney

Think about the people who mean the most to you. Who do you trust to talk to your healthcare team about what is important to you and the kinds of treatments you do or do not want?

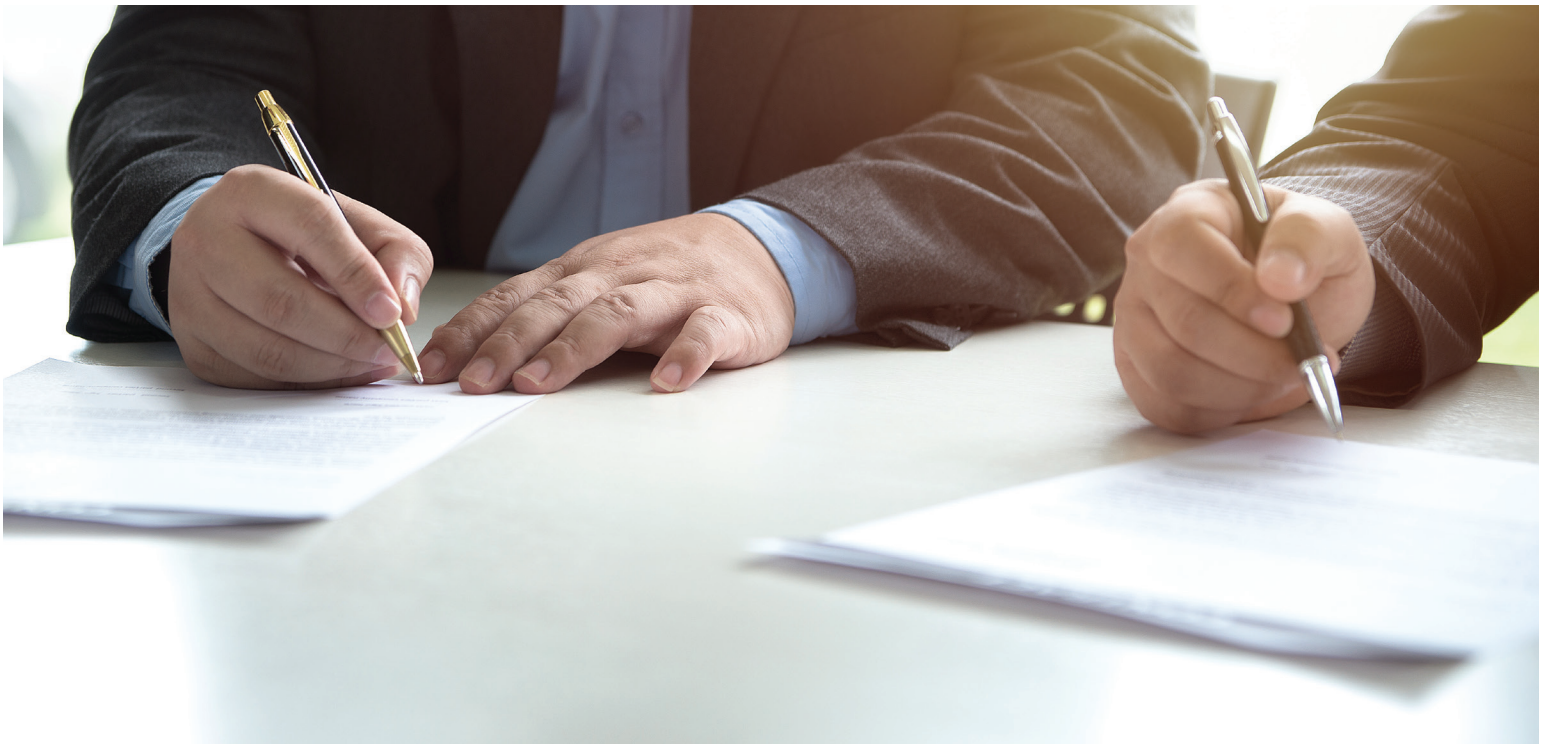
A healthcare power of attorney is someone you choose to make medical decisions on your behalf when you are too sick to make them yourself. People often choose a spouse, child, relative or friend.

**Reflect on the following:**

1. If the situation occurred where you could not speak for yourself, have you considered who would make medical decisions for you?
2. Even if you know who you want to make medical decisions on your behalf, have you officially designated this person to be your healthcare power of attorney?

After you choose a healthcare power of attorney, talk to this person about your wishes. Then, complete the Healthcare Power of Attorney document, and discuss it with your physician during your next visit.

Ochsner LSU Health Shreveport healthcare professionals will always confirm your wishes with you or your healthcare power of attorney should you get sick.



Ochsner LSU Health Shreveport
Advance Directive

Power of Attorney for Healthcare Decisions

## The Person I Want To Make Healthcare Decisions For Me When I Cannot Make Them For Myself

If I, _____ , being of sound mind, am no longer able to make my own healthcare decisions, the person I choose as my Healthcare Power of Attorney is:

**(First Choice Name)** _____

(Address) _____ (Phone Number) _____

If this person is not able to or willing to make these choices for me, or is divorced or legally separated from me, or this person has died, then these people are my next choices:

**(Second Choice Name)** _____ **(Third Choice Name)** _____

(Address) _____ (Address) _____

(City/State/Zip) _____ (City/State/Zip) _____

(Phone) _____ (Phone) _____

I understand that my Healthcare Power of Attorney can make healthcare decisions for me. I want my Healthcare Power of Attorney to be able to do the following:
**Please cross out/strike through all of the items you do NOT want your agent/attorney in fact to do.**

Make better healthcare and treatment decisions for me.

Make decisions concerning surgery.

Make decisions concerning medical expenses.

Make decisions concerning hospitalizations.

Make decisions concerning nursing home residency.

Take any legal action needed to carry out my wishes.

Make decisions concerning the withholding or withdrawal of life-sustaining procedures.

Make decisions concerning medications.

See and approve the release of my medical record.

Make decisions concerning selection of physicians.

Apply for Medicare/Medicaid or other programs for insurance.

Such Healthcare Power of Attorney has full authority to make such decisions as fully, completely and effectually, and to all intents and purposes with the same validity, as if I had personally made such decisions.

This Healthcare Power of Attorney is effective immediately, and serves to revoke and supersede any prior Healthcare Power of Attorney that I have previously executed. This Healthcare Power of Attorney will continue until it is revoked.

This declaration is made by me and signed on this _____ day of _____ in the year _____, in the presence of the undersigned witnesses who are not entitled to any portion of my estate.

Signed: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

**Witness Acknowledgement:** The Declarant is and has personally been known to me, and I believe the Declarant to be of sound mind. I am not related to the Declarant by blood or marriage, and would not be entitled to any portion of Declarant's estate upon his/her death. I was physically present and personally witnessed the Declarant execute the foregoing Declaration.

_____ _____

Witness Signature / Print Witness Name/Date/Time Witness Signature / Print Witness Name/Date/Time

## Step 2: Determine what is important to you

Everyone has a different idea about what quality of life means, what makes life meaningful and what makes life worth living. There are no right or wrong choices. What matters most is that you have taken the time to think about this in advance and communicated your preferences to your decision-maker and doctors.

**Consider these three medical treatment options:**

A. I want to have life-support treatment.

B. I want to have life-support treatment if my doctor believes it can help. However, I want my doctor to stop giving me life-support treatment if it is not helping my condition.

C. I do not want life-support treatment. If it has been started, I want it stopped.

For the following situations, decide the medical treatment you would or would not want to receive, and write the letter for it to reflect your wishes.

**Situation 1**
My doctor and another healthcare professional both decide I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death.
My wishes in this situation are: _____

**Situation 2**
My doctor and another healthcare professional both have determined I am in a coma from which I am not expected to wake up or recover. Life-support treatment would only delay the moment of my death. My wishes in this situation are: _____

**Situation 3**
My doctor and another healthcare professional both agree I have permanent and severe brain damage. I can open my eyes, but I can't speak or comprehend. I am not expected to get better. Life-support treatment would only delay the moment of my death.
My wishes in this situation are: _____

**Situation 4**
My physical condition is one where I can no longer comprehend what is happening around me. I cannot speak or do things on my own, such as eating or using the bathroom.
My wishes in this situation are: _____

Either by yourself or with your designated healthcare power of attorney, complete the Living Will document, so your doctors can have a clear understanding of your preferences.

Ochsner LSU Health Shreveport healthcare professionals will always confirm your wishes with you or your healthcare power of attorney should you get sick.

Ochsner LSU Health Shreveport
Advance Directive
Living Will

Withholding or Withdrawal of Life-Sustaining Medical Procedures
(LA.REV.STAT.40:1299.58.3)

## The Kind of Medical Treatment I Want or Do Not Want

I, _____, believe that my life is precious, and I deserve to be treated with dignity. If the time comes that I am very sick and am not able to speak for myself, I would like for my wishes to be respected and followed. The instructions that I am including in this section are to let my family, my doctors and other healthcare providers, my friends, and all others know the kind of medical treatment that I want or do not want.

If at any time I should have an incurable injury, disease or illness, or be in a continual, profound comatose state with no reasonable chance of recovery, certified to be in a terminal and irreversible condition by two physicians who have personally examined me, one of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to artificially prolong the dying process, then I would like the following instructions to be followed.
Choose one of the following:

☐ That all life-sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.

☐ That life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

I further direct that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal. I understand the full impact of this declaration, and I am emotionally and mentally competent to make this decision.

This declaration is made and signed by me on this _____ day of _____ in the year _____, in the presence of the undersigned witnesses who are not entitled to any portion of my estate.

Signed: _____

Address: _____

Date of Birth: _____ Social Security Number: _____

**Witness Acknowledgement:** The Declarant is and has personally been known to me, and I believe the Declarant to be of sound mind. I am not related to the Declarant by blood or marriage, and would not be entitled to any portion of Declarant's estate upon his/her death. I was physically present and personally witnessed the Declarant execute the foregoing Declaration.

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