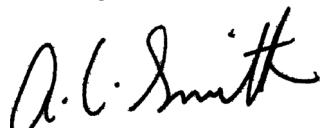




Department of
Rehabilitation & Correction

SUBJECT: Advance Directives for Health Care	PAGE <u> 1 </u> OF <u> 3 </u> NUMBER: 69-OCH-03
RULE/CODE REFERENCE: ORC 1337.12, 2133, 5120.01	SUPERSEDES: 69-OCH-03 dated 01/27/2011
RELATED ACA STANDARDS:	EFFECTIVE DATE: June 1, 2021
	APPROVED: 

I. AUTHORITY

Ohio Revised Code 5120.01 authorizes the Director of the Department of Rehabilitation and Correction, as the executive head of the department, to direct the total operations and management of the department by establishing procedures as set forth in this policy.

II. PURPOSE

The purpose of this policy is to establish a procedure consistent with Ohio Revised Code (ORC) sections 1337.12 and 2133 so that incarcerated individuals may be provided with standard forms that communicate the incarcerated individual's wishes about his/her health care should he/she no longer be able to communicate such wishes.

III. APPLICABILITY

This policy shall be applicable to all persons employed by or under contract with the Ohio Department of Rehabilitation and Correction (ODRC) and all incarcerated individuals in institutions operated by the ODRC. This policy is not applicable to the Division of Parole and Community Services (DPCS).

IV. DEFINITIONS

The definitions for the below listed terms can be found at the top of the ODRC policies page on the ODRC Intranet at the following:

[Definitions Link](#)

- **Advance Directives**
- **Attorney-in-Fact**
- **Durable Powers of Attorney**
- **Living Will**

V. POLICY

It is the policy of the ODRC to facilitate an incarcerated individual's desire to direct his/her health care should he/she no longer be in a condition to make informed choices. Correctly completed forms that have been witnessed or notarized shall be honored pursuant to ORC sections 1337.12 and 2133 and may be revoked at any time.

VI. PROCEDURES

- A. The attached documents, the State of Ohio Health Care Power of Attorney (Attachment A) and the State of Ohio Living Will Declaration (Attachment B), were designed to conform to all procedural requirements and should satisfy the majority of situations that will require their use. Although it is anticipated that these forms will be the standard documents used throughout Ohio, there may be circumstances that will require departure from the usual and customary forms.
- B. Each institution shall make the following forms for advance directives for health care available in the institution library for any incarcerated individuals who desire them:
 - 1. State of Ohio Health Care Power of Attorney (Attachment A)
 - 2. State of Ohio Living Will Declaration (Attachment B)
- C. During admission to an ODRC facility or to OSU, each incarcerated individual shall be given information about advanced directives and shall be given the opportunity to complete an Advance Directive form, as outlined in section VI.B of this policy.
- D. It is not the responsibility of the institution staff to provide legal assistance or interpretation of form language.
 - 1. Assistance regarding the completion of the forms may be obtained from unit case managers and/or social workers at inpatient facilities.
 - 2. It is the incarcerated individual's responsibility to ask their legal counsel for explanation of anything contained in the forms that he/she does not understand.
- E. It is the incarcerated individual's responsibility to fully complete the form(s) and have such form(s) properly witnessed and notarized. The incarcerated individual should retain a personal copy and distribute copies to Health Services for appropriate placement in the incarcerated individual's medical file.
- F. No incarcerated individual may be designated as Attorney-in-Fact in the Durable Powers of Attorney of another incarcerated individual.
- G. Advance directives are effective when an incarcerated individual signs and distributes the appropriate forms.
 - 1. It is not necessary to undergo any court procedure.

2. The attending physician must determine that the incarcerated individual is unable to make health care decisions for him/herself before the Durable Powers of Attorney for Health Care may be used.

H. An incarcerated individual may revoke an advance directive at any time. The incarcerated individual should collect all the documents that he/she distributed or rescind them in writing to avoid confusion.

Attachments:

Attachment A State of Ohio Health Care Power of Attorney
Attachment B State of Ohio Living Will Declaration

State of Ohio
Health Care Power of Attorney
of

(Print Full Name)

(Birth Date)

I state that this is my Health Care Power of Attorney and I revoke any prior Health Care Power of Attorney signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

This Health Care Power of Attorney is in effect only when I cannot make health care decisions for myself. However, this does not require or imply that a court must declare me incompetent.

Definitions. Several legal and medical terms are used in this document. For convenience they are explained below.

Agent or attorney-in-fact means the adult I name in this Health Care Power of Attorney to make health care decisions for me.

Anatomical gift means a donation of all or part of a human body to take effect upon or after death.

Artificially or technologically supplied nutrition or hydration means the providing of food and fluids through intravenous or tube “feedings.”

Cardiopulmonary resuscitation or CPR means treatment to try to restart breathing or heartbeat. CPR may be done by breathing into the mouth, pushing on the chest, putting a tube through the mouth or nose into the throat, administering medication, giving electric shock to the chest, or by other means.

Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

Donor Registry Enrollment Form means a form that has been designed to allow individuals to specifically register their wishes regarding organ, tissue and eye donation with the Ohio Bureau of Motor Vehicles Donor Registry.

Do Not Resuscitate or DNR Order means a medical order given by my physician and written in my medical records that cardiopulmonary resuscitation or CPR is not to be administered to me.

Health care means any medical (including dental, nursing, psychological, and surgical) procedure, treatment, intervention or other measure used to maintain, diagnose or treat any physical or mental condition.

Health Care Power of Attorney means this document that allows me to name an adult person to act as my agent to make health care decisions for me if I become unable to do so.

Life-sustaining treatment means any health care, including artificially or technologically supplied nutrition and hydration, that will serve mainly to prolong the process of dying.

Living Will Declaration or Living Will means another document that lets me specify the health care I want to receive if I become terminally ill or permanently unconscious and cannot make my wishes known.

Permanently unconscious state means an irreversible condition in which I am permanently unaware of myself and surroundings. My physician and one other physician must examine me and agree that the total loss of higher brain function has left me unable to feel pain or suffering.

Principal means the person signing this document.

Terminal condition or terminal illness means an irreversible, incurable and untreatable condition caused by disease, illness or injury. My physician and one other physician will have examined me and believe that I cannot recover and that death is likely to occur within a relatively short time if I do not receive life-sustaining treatment.

[Instructions and other information to assist in completing this document are set forth within brackets and in italic type.]

Naming of My Agent. The person named below is my agent who will make health care decisions for me as authorized in this document.

Agent's Name: _____

Agent's Current Address: _____

Agent's Current Telephone Number: _____

Naming of Alternate Agents. [Note: You do not need to name alternate agents. You also may name just one alternate agent. If you do not name alternate agents or name just one alternate agent, you may wish to cross out the unused lines.]

Should my agent named above not be immediately available or be unwilling or unable to make decisions for me, then I name, in the following order of priority, the following persons as my alternate agents:

First Alternate Agent:

Second Alternate Agent:

Name: _____

Name: _____

Address: _____

Address: _____

Telephone: _____

Telephone: _____

Any person can rely on a statement by any alternate agent named above that he or she is properly acting under this document and such person does not have to make any further investigation or inquiry.

Guidance to Agent. My agent will make health care decisions for me based on the instructions that I give in this document and on my wishes otherwise known to my agent. If my agent believes that my wishes as made known to my agent conflict with what is in this document, this document will control. If my wishes are unclear or unknown, my agent will make health care decisions in my best interests. My agent will determine my best interests after considering the benefits, the burdens, and the risks that might result from a given decision. If no agent is available, this document will guide decisions about my health care.

Authority of Agent. My agent has full and complete authority to make all health care decisions for me whenever I cannot make such decisions, unless I have otherwise indicated below. This authority includes, but is not limited to, the following: *[Note: Cross out any authority that you do **not** want your agent to have.]*

1. To consent to the administration of pain-relieving drugs or treatment or procedures (including surgery) that my agent, upon medical advice, believes may provide comfort to me, even though such drugs, treatment or procedures may hasten my death. My comfort and freedom from pain are important to me and should be protected by my agent and physician.
2. If I am in a terminal condition, to give, to withdraw or to refuse to give informed consent to life-sustaining treatment, including artificially or technologically supplied nutrition or hydration.
3. To give, withdraw or refuse to give informed consent to any health care procedure, treatment, intervention or other measure.
4. To request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, all my medical and health care records.
5. To consent to further disclosure of information, and to disclose medical and related information concerning my condition and treatment to other persons.
6. To execute for me any releases or other documents that may be required in order to obtain medical and related information.
7. To execute consents, waivers, and releases of liability for me and for my estate to all persons who comply with my agent's instructions and decisions. To indemnify and hold harmless, at my expense, any third party who acts under this Health Care Power of Attorney. I will be bound by such indemnity entered into by my agent.
8. To select, employ, and discharge health care personnel and services providing home health care and the like.
9. To select, contract for my admission to, transfer me to, or authorize my discharge from any medical or health care facility, including, but not limited to, hospitals, nursing homes, assisted living facilities, hospices, adult homes and the like.
10. To transport me or arrange for my transportation to a place where this Health Care Power of Attorney is honored, should I become unable to make health care decisions for myself in a place where this document is not enforced.

11. To complete and sign for me the following:

- (a) Consents to health care treatment, or the issuance of Do Not Resuscitate (DNR) Orders or other similar orders; and
- (b) Requests for my transfer to another facility, to be discharged against health care advice, or other similar requests; and
- (c) Any other document desirable to implement health care decisions that my agent is authorized to make pursuant to this document.

Special Instructions. By placing my initials at number 3 below, I want to specifically authorize my agent to refuse, or if treatment has commenced, to withdraw consent to, the provision of artificially or technologically supplied nutrition or hydration if:

1. I am in a permanently unconscious state; and
2. My physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain; and
3. I have placed my initials on this line: _____

Limitations of Agent's Authority. I understand that under Ohio law, there are five limitations to the authority of my agent:

1. My agent cannot order the withdrawal of life-sustaining treatment unless I am in a terminal condition or a permanently unconscious state, and two physicians have confirmed the diagnosis and have determined that I have no reasonable possibility of regaining the ability to make decisions; and
2. My agent cannot order the withdrawal of any treatment given to provide comfort care or to relieve pain; and
3. If I am pregnant, my agent cannot refuse or withdraw informed consent to health care if the refusal or withdrawal would end my pregnancy, unless the pregnancy or health care would create a substantial risk to my life or two physicians determine that the fetus would not be born alive; and

No Expiration Date. This Health Care Power of Attorney will have no expiration date and will not be affected by my disability or by the passage of time.

Guardian. I intend that the authority given to my agent will eliminate the need for any court to appoint a guardian of my person. However, should such proceedings start, I nominate my agent to serve as the guardian of my person, without bond.

Enforcement by Agent. My agent may take for me, at my expense, any action my agent considers advisable to enforce my wishes under this document.

Release of Agent's Personal Liability. My agent will not incur any personal liability to me or my estate for making reasonable choices in good faith concerning my health care.

Copies the Same as Original. Any person may rely on a copy of this document.

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law.

Living Will. I have completed a Living Will: _____ Yes _____ No

Anatomical Gift(s). I have made my wishes known regarding organ and tissue donation in my Living Will: _____ Yes _____ No

Donor Registry Enrollment Form. I have completed the Donor Registry Enrollment Form: _____ Yes _____ No

SIGNATURE

[See next page for witness or notary requirements.]

I understand the purpose and effect of this document and sign my name to this Health Care Power of Attorney on _____, 20 _____, at _____, Ohio.

PRINCIPAL

[You are responsible for telling members of your family and your physician about this document and the name of your agent. You also may wish, but are not required to tell your religious advisor and your lawyer that you have signed a Health Care Power of Attorney. You may wish to give a copy to each person notified.]

[You may choose to file a copy of this Health Care Power of Attorney with your county recorder for safekeeping.]

WITNESSES OR NOTARY ACKNOWLEDGMENT

[Choose one.]

[This Health Care Power of Attorney will not be valid unless it either is signed by two eligible witnesses who are present when you sign or are present when you acknowledge your signature, or it is acknowledged before a Notary Public.]

[The following persons **cannot** serve as a witness to this Health Care Power of Attorney: the agent; any successor agent named in this document; your spouse; your children; anyone else related to you by blood, marriage or adoption; your attending physician; or, if you are in a nursing home, the administrator of the nursing home.]

Witnesses. I attest that the Principal signed or acknowledged this Health Care Power of Attorney in my presence, that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence. I further attest that I am not an agent designated in this document, I am not the attending physician of the Principal, I am not the administrator of a nursing home in which the Principal is receiving care, and I am an adult not related to the Principal by blood, marriage or adoption.

_____ residing at _____
Signature

_____, _____
Print Name

Dated: _____, 20_____

_____ residing at _____
Signature

_____, _____
Print Name

Dated: _____, 20_____

OR

Notary Acknowledgment.

State of Ohio

County of _____ ss.

On _____, 20_____, before me, the undersigned Notary Public, personally appeared _____, known to me or satisfactorily proven to be the person whose name is subscribed to the above Health Care Power of Attorney as the Principal, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the Principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

Notary Public

My Commission Expires: _____

[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]

NOTICE TO ADULT EXECUTING THIS DOCUMENT

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact NEVER will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:

(a) You are suffering from an irreversible, incurable and untreatable condition caused by disease, illness, or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]

(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if the attorney in fact is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). **(You should understand that comfort care is defined in Ohio law to mean artificially or technologically administered sustenance (nutrition) or fluids (hydration) when administered to diminish your pain or discomfort, not to postpone your death, and any other medical or nursing procedure, treatment, intervention, or other measure that would be taken to diminish your pain or discomfort, not to postpone your death. Consequently, if your attending physician were to determine that a previously described medical or nursing procedure, treatment, intervention, or other measure will not or no longer will serve to provide comfort to you or alleviate your pain, then, subject to (4) below, your attorney in fact would be authorized to refuse or withdraw informed consent to the procedure, treatment, intervention, or other measure.);**

(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) Refuse or withdraw informed consent to the provision of artificially or technologically administered sustenance (nutrition) or fluids (hydration) to you, unless:

(a) You are in a terminal condition or in a permanently unconscious state.

[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]

(b) Your attending physician and at least one other physician who has examined you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain.

(c) If, but only if, you are in a permanently unconscious state, you authorize the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you by doing both of the following in this document:

(i) Including a statement in capital letters or other conspicuous type, including, but not limited to, a different font, bigger type, or boldface type, that the attorney in fact may refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state and if the determination that nutrition or hydration will not or no longer will serve to provide comfort to you or alleviate your pain is made, or checking or otherwise marking a box or line (if any) that is adjacent to a similar statement on this document;

(ii) Placing your initials or signature underneath or adjacent to the statement, check, or other mark previously described.

(d) Your attending physician determines, in good faith, that you authorized the attorney in fact to refuse or withdraw informed consent to the provision of nutrition or hydration to you if you are in a permanently unconscious state by complying with the above requirements of (4)(c)(i) and (ii) above.

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to the attorney in fact in another manner.

When acting pursuant to this document, the attorney in fact GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

[This notice is included in this printed form as required by Ohio Revised Code § 1337.17.]

Generally, you may designate any competent adult as the attorney in fact under this document. However, you CANNOT designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you CANNOT designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.

This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicates it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

If there is anything in this document that you do not understand, you should ask your lawyer to explain it to you.

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State of Ohio Living Will Declaration Notice to Declarant

The purpose of this Living Will Declaration is to document your wish that life-sustaining treatment, including artificially or technologically supplied nutrition and hydration, be withheld or withdrawn if you are unable to make informed medical decisions and are in a terminal condition or in a permanently unconscious state. This Living Will Declaration does not affect the responsibility of health care personnel to provide comfort care to you. Comfort care means any measure taken to diminish pain or discomfort, but not to postpone death.

If you would not choose to limit any or all forms of life-sustaining treatment, including CPR, you have the legal right to so choose and may wish to state your medical treatment preferences in writing in a different document.

Under Ohio law, a Living Will Declaration is applicable **only to individuals in a terminal condition or a permanently unconscious state**. If you wish to direct medical treatment in other circumstances, you should prepare a Health Care Power of Attorney. If you are in a terminal condition or a permanently unconscious state, this Living Will Declaration takes precedence over a Health Care Power of Attorney.

[You should consider completing a new Living Will Declaration if your medical condition changes or if you later decide to complete a Health Care Power of Attorney. If you have both a Living Will Declaration and a Health Care Power of Attorney, you should keep copies of these documents together. Bring your document(s) with you whenever you are a patient in a health care facility or when you update your medical records with your physician.]



Ohio Living Will Declaration

[R.C. §2133]

(Print Full Name)

(Birth Date)

This is my Living Will Declaration. I revoke all prior Living Will Declarations signed by me. I understand the nature and purpose of this document. If any provision is found to be invalid or unenforceable, it will not affect the rest of this document.

I am of sound mind and not under or subject to duress, fraud or undue influence. I am a competent adult who understands and accepts the consequences of this action. I voluntarily declare my direction that my dying not be artificially prolonged. [R.C. §2133.02 (A)(1)]

I intend that this Living Will Declaration will be honored by my family and physicians as the final expression of my legal right to refuse certain health care. [R.C. §2133.03(B)(2)]

Definitions

Adult means a person who is 18 years of age or older.

Agent or attorney-in-fact means a competent adult who a person (the “principal”) can name in a Health Care Power of Attorney to make health care decisions for the principal.

Anatomical gift means a donation of part or all of a human body to take effect after the donor’s death for the purpose of transplantation, therapy, research or education.

Artificially or technologically supplied nutrition or hydration means food and fluids provided through intravenous or tube feedings. *[You can refuse or discontinue a feeding tube, or authorize your Health Care Power of Attorney agent to refuse or discontinue artificial nutrition or hydration.]*

Comfort care means any measure, medical or nursing procedure, treatment or intervention, including nutrition and or hydration, that is taken to diminish a patient’s pain or discomfort, but not to postpone death.

CPR means cardiopulmonary resuscitation, one of several ways to start a person’s breathing or heartbeat once either has stopped. It does not include clearing a person’s airway for a reason other than resuscitation.

Declarant means the person signing the Living Will Declaration.

Do Not Resuscitate or DNR Order means a physician’s medical order that is written into a patient’s record to indicate that the patient should not receive cardiopulmonary resuscitation.

Health care means any care, treatment, service or procedure to maintain, diagnose or treat an individual’s physical or mental health.

Health care decision means giving informed consent, refusing to give informed consent, or withdrawing informed consent to health care.

Health Care Power of Attorney means a legal document that lets the principal authorize an agent to make health care decisions for the principal in most health care situations when the principal can no longer make such decisions. Also, the principal can authorize the agent to gather protected health information for and on behalf of the principal immediately or at any other time. A Health Care Power of Attorney is NOT a financial power of attorney.

The Health Care Power of Attorney document also can be used to nominate person(s) to act as guardian of the principal's person or estate. Even if a court appoints a guardian for the principal, the Health Care Power of Attorney remains in effect unless the court rules otherwise.

Life-sustaining treatment means any medical procedure, treatment, intervention or other measure that, when administered to a patient, mainly prolongs the process of dying.

Living Will Declaration means a legal document that lets a competent adult (“declarant”) specify what health care the declarant wants or does not want when he or she becomes terminally ill or permanently unconscious and can no longer make his or her wishes known. It is NOT and does not replace a will, which is used to appoint an executor to manage a person’s estate after death.

Permanently unconscious state means an irreversible condition in which the patient is permanently unaware of himself or herself and surroundings. At least two physicians must examine the patient and agree that the patient has totally lost higher brain function and is unable to suffer or feel pain.

Principal means a competent adult who signs a Health Care Power of Attorney.

Terminal condition means an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which, to a reasonable degree of medical certainty as determined in accordance with reasonable medical standards by a declarant's attending physician and one other physician who has examined the declarant, both of the following apply: (1) there can be no recovery and (2) death is likely to occur within a relatively short time if life-sustaining treatment is not administered.

No Expiration Date. This Living Will Declaration will have no expiration date. However, I may revoke it at any time. [R.C. §2133.04(A)]

Copies the Same as Original. Any person may rely on a copy of this document. [R.C. §2133.02(C)]

Out of State Application. I intend that this document be honored in any jurisdiction to the extent allowed by law. [R.C. §2133.14]

I have completed a **Health Care Power of Attorney:** Yes No

Notifications. [Note: You do not need to name anyone. If no one is named, the law requires your attending physician to make a reasonable effort to notify one of the following persons in the order named: your guardian, your spouse, your adult children who are available, your parents, or a majority of your adult siblings who are available.]

In the event my attending physician determines that life-sustaining treatment should be withheld or withdrawn, my physician shall make a reasonable effort to notify one of the persons named below, in the following order of priority [cross out any unused lines]: [R.C. §2133.05(2)(a)]

X out area if not used	First contact's name and relationship: _____
	Address: _____
	Telephone number(s): _____
	Second contact's name and relationship: _____
	Address: _____
	Telephone number(s): _____
	Third contact's name and relationship: _____
	Address: _____
	Telephone number(s): _____

If I am in a **TERMINAL CONDITION** and unable to make my own health care decisions, OR if I am in a **PERMANENTLY UNCONSCIOUS STATE** and there is no reasonable possibility that I will regain the capacity to make informed decisions, then I direct my physician to let me die naturally, providing me only with **comfort care**.

For the purpose of providing comfort care, I authorize my physician to:

1. Administer no life-sustaining treatment, including CPR;
2. Withhold or withdraw artificially or technologically supplied nutrition or hydration, provided that, if I am in a permanently unconscious state, I have authorized such withholding or withdrawal under **Special Instructions** below and the other conditions have been met;
3. Issue a DNR Order; and
4. Take no action to postpone my death, providing me with only the care necessary to make me comfortable and to relieve pain.

Special Instructions.

By placing my initials, signature, check or other mark in this box, I specifically authorize my physician to withhold, or if treatment has commenced, to withdraw, consent to the provision of artificially or technologically supplied nutrition or hydration if I am in a permanently unconscious state AND my physician and at least one other physician who has examined me have determined, to a reasonable degree of medical certainty, that artificially or technologically supplied nutrition and hydration will not provide comfort to me or relieve my pain. [R.C. §2133.02(A)(3) and R.C. §2133.08]

Additional instructions or limitations.

*[If the space below is not sufficient, you may attach additional pages.
If you do not have any additional instructions or limitations, write "None" below.]*

[The "anatomical gift" language provided below is required by ORC §2133.07(C). Donate Life Ohio recommends that you indicate your authorization to be an organ, tissue or cornea donor at the Ohio Bureau of Motor Vehicles when receiving a driver license or, if you wish to place restrictions on your donation, on a Donor Registry Enrollment Form (attached) sent to the Ohio Bureau of Motor Vehicles.]

[If you use this living will to declare your authorization, indicate the organs and/or tissues you wish to donate and cross out any purposes for which you do not authorize your donation to be used. Please see the attached Donor Registry Enrollment Form for help in this regard. In all cases, let your family know your declared wishes for donation.]

ANATOMICAL GIFT (optional)

Upon my death, the following are my directions regarding donation of all or part of my body: In the hope that I may help others upon my death, I hereby give the following body parts: *[Check all that apply.]*

All organs, tissue and eyes for any purposes authorized by law.

OR

The following selected items:

- | | | | |
|---------------------------------------|-------------------------------------|---|---|
| <input type="checkbox"/> Heart | <input type="checkbox"/> Lungs | <input type="checkbox"/> Liver (and associated vessels) | <input type="checkbox"/> Pancreas/Islet Cells |
| <input type="checkbox"/> Small Bowel | <input type="checkbox"/> Intestines | <input type="checkbox"/> Kidneys (and associated vessels) | <input type="checkbox"/> Eyes/Corneas |
| <input type="checkbox"/> Heart Valves | <input type="checkbox"/> Bone | <input type="checkbox"/> Tendons | <input type="checkbox"/> Ligaments |
| <input type="checkbox"/> Veins | <input type="checkbox"/> Fascia | <input type="checkbox"/> Skin | <input type="checkbox"/> Nerves |

For the following purposes authorized by law:

- All purposes Transplantation Therapy Research Education

If I do not indicate a desire to donate all or part of my body by filling in the lines above, no presumption is created about my desire to make or refuse to make an anatomical gift.

SIGNATURE of DECLARANT

I understand that I am responsible for telling members of my family, the agent named in my Health Care Power of Attorney (if I have one), my physician, my lawyer, my religious advisor and others about this Living Will Declaration. I understand I may give copies of this Living Will Declaration to any person.

I understand that I must sign (or direct an individual to sign for me) this Living Will Declaration and state the date of the signing, and that the signing either must be witnessed by two adults who are eligible to witness the signing OR the signing must be acknowledged before a notary public. [R.C. §2133.02]

I sign my name to this Living Will Declaration

on _____, 20____, at _____, Ohio.

Declarant

[Choose Witnesses OR a Notary Acknowledgment.]

WITNESSES [R.C. §2133.02(B)(1)]

[The following persons CANNOT serve as a witness to this Living Will Declaration:

- *Your agent in your Health Care Power of Attorney, if any;*
- *The guardian of your person or estate, if any;*



- Any alternate agent or guardian, if any;
- Anyone related to you by blood, marriage or adoption (for example, your spouse and children);
- Your attending physician; and
- The administrator of the nursing home where you are receiving care.]

I attest that the Declarant signed or acknowledged this Living Will Declaration in my presence, and that the Declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

_____/_____/_____
 Witness One's Signature Witness One's Printed Name Date

 Witness One's Address

_____/_____/_____
 Witness Two's Signature Witness Two's Printed Name Date

 Witness Two's Address

OR, if there are no witnesses,

NOTARY ACKNOWLEDGMENT [R.C. §2133.02(B)(2)]

State of Ohio

County of _____ ss.

On _____, 20____, before me, the undersigned notary public, personally appeared _____, declarant of the above Living Will Declaration, and who has acknowledged that (s)he executed the same for the purposes expressed therein. I attest that the declarant appears to be of sound mind and not under or subject to duress, fraud or undue influence.

 Notary Public

My Commission Expires: _____

My Commission is Permanent: _____

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Ohio's Do-Not-Resuscitate Law

What You Should Know About Do-Not-Resuscitate (DNR) Laws in Ohio

Ohio's Do-Not-Resuscitate (DNR) Law gives individuals the opportunity to exercise their right to limit care received in emergency situations in special circumstances. "Special circumstances" include care received from emergency personnel when 911 is dialed. The law authorizes a physician to write an order letting health care personnel know that a patient does not wish to be resuscitated in the event of a cardiac arrest (no palpable pulse) or respiratory arrest (no spontaneous respirations or the presence of labored breathing).

The following information is included as a brief overview of some of the more common questions, issues and concerns regarding Ohio's Do-Not-Resuscitate law. It is not meant to provide all information needed to make the decision to have a Do-Not-Resuscitate order written. An individual may have a DNR order written after **consultation** with his or her physician regarding end-of-life issues.

The DNR order may be honored in multiple settings, including but not limited to: nursing facilities, residential care facilities, hospitals, outpatient areas, home, and public places. For a DNR order to be useful in multiple settings, it must be recognizable by health care workers. The Ohio Department of Health has developed a standard order form that is generally recognized. You may choose to display the form in your residence to be easily visible to healthcare personnel and transport it with you when you are away from home. Other DNR identifications, including a wallet identification card, may be used but must include the Ohio DNR logo to be valid.

Unlike a Living Will and Health Care Power of Attorney which can be executed without the input of a healthcare professional, a DNR Order must be written and signed by a physician, an advanced-practice nurse, certified nurse practitioner or physician assistant after consultation with the patient.

DNR order on the state approved document is legally-sanctioned and implemented according to Ohio Law. The DNR order is implemented at different points, depending upon the patient's wishes and must be consistent with reasonable medical standards.

Care that eases pain and suffering will always be implemented regardless of a DNR order. Other related care will be provided depending on the specific order that your physician prescribes. Your should check with your prescriber regarding the right type of DNR order needed when considering your specific medical needs.



DNR/CPR Care: The Facts

Ohio first adopted a law concerning DNR orders in 1998. DNR stands for “do not resuscitate.” A person who does not wish to have cardiopulmonary resuscitation (CPR) performed may make this wish known through a physician’s order called a DNR order. A DNR order addresses the various methods used to revive people whose hearts have stopped functioning or who have stopped breathing.

Cardiopulmonary Resuscitation (CPR) has a broad meaning. It includes any or all of the following:

- ◆ Administration of chest compressions;
- ◆ Insertion of an artificial airway;
- ◆ Administration of resuscitation drugs;
- ◆ Defibrillation or cardioversion;
- ◆ Provision of respiratory assistance;
- ◆ Initiation of a resuscitative intravenous line; or
- ◆ Initiation of cardiac monitoring.

CPR can be life-saving but some people may not want it administered in certain cases.

In some cases, CPR saves lives. In many cases, it is not effective. Many people overestimate the success of CPR. A person who is revived may be left with permanent or painful injury. Resuscitation also may include other treatment, such as drugs, tubes and electric shock. People with terminal illnesses or other serious medical conditions may prefer to focus on comfort care at the end of life rather than receiving CPR when the time comes. For more information about the pros and cons of CPR and whether it is right for you, ask your physician.

It is easy to make your wishes about CPR known.

If you want to receive CPR when appropriate, you do not need to do anything. Health care providers are required to perform CPR when necessary. If you do not want CPR, you need to discuss your wishes with your physician and ask your physician to write a DNR Order. If your physician agrees that you should not get CPR, he or she can fill out the required form to make your wishes known in case of an emergency.

There are different DNR orders that you can choose and discuss with your physician.

Under Ohio’s DNR Law, the Ohio Department of Health has established a standardized DNR form. When completed by a physician (certified nurse practitioner or advance practice nurse, as appropriate), these standardized DNR orders allow patients to choose the extent of the treatment they wish to receive or not receive at the end of life. Your physician can further explain the differences in DNR orders.

Even if you are healthy now, you may want to state that you do not want to receive CPR if you ever become terminally ill.

Ohio has a standard Living Will Declaration form. This form specifically allows you to direct your physician not to administer life-sustaining treatments, including CPR, and to issue a DNR Order if two physicians have agreed that you are either terminally ill or permanently unconscious.



DNR Comfort Care does NOT mean “Do Not Treat.”

The DNR Comfort Care Protocol is very specific in terms of what treatment is to be given and what treatment is to be withheld. Only those items listed on the “will not” list are to be withheld. The items listed on the “will” list, along with any other treatment that may be needed for the patient’s condition, may be provided as appropriate.

DNR Orders may be revoked.

You always have the right to change your mind and request CPR. If you do change your mind, you should speak with your physician right away about revoking your DNR Order. You also should tell your family and caregivers about your decision and throw away any DNR identification items you might have.

If you have a DNR Order or identification, your family cannot demand that CPR be provided.

You have the right to make your own decisions about your health care. You should make sure your family knows your desires about CPR. In certain medical situations, your physician and agent may make decisions regarding your care based upon new medical information. This could include decisions related to CPR. You should make sure these individuals know your desires about CPR.

Since a DNR is a medical order, you need a physician to write and sign it for you.

Unlike Living Wills and Health Care Powers of Attorney, DNR Orders must be written and signed by a physician, advanced practice nurse or certified nurse practitioner after consultation with the patient.

Copies of these forms should be kept in easily accessible places where others can find them.

You also should give copies of your Living Will, Health Care Power of Attorney and/or DNR Order to your physician, family members and any close friends who might serve as caretakers. **At home, a DNR order should be displayed prominently either on the refrigerator or elsewhere so that an emergency responder will see it.**





The Hospice Choice

When choices seem few and unpleasant...

... there is hospice. Life is full of choices. We all want to be in control, capable of making our own decisions, and determine how we live our lives. When cure is no longer possible, we experience fear, frustration and confusion. We can feel as if we have lost control of our lives. Hospice helps to restore our ability to make decisions, to put life back on track by offering positive choices as we confront life's end.

What does hospice offer?

Hospice provides care for a patient by an interdisciplinary team comprised of physicians, nurses, social workers, counselors, home health aides, chaplains, therapists and volunteers as needed. In addition, hospices help provide medications, durable medical equipment, supplies and inpatient care. The hospice provides care on a 24-hour, 7-day a week basis, always there to assist with crises or concerns that may arise.

Moreover, hospice is a philosophy of care which wraps around patient wishes: your wishes will be respected and that you will be allowed to die, as pain free as possible, surrounded by those who love you, and with the utmost respect and dignity. Hospice focuses on improving the quality of life that remains, rather than just increasing the quantity.

When can I choose hospice?

People who choose hospice have medical conditions that no longer can be cured, and who are approaching the last phase of life. Hospice, with more than four decades of experience in caring for the terminally ill, offers tremendous advances in pain management that dramatically improve quality of life.

Where is hospice care provided?

Hospice services generally are provided in the soothing, familiar surroundings of your home where you are most comfortable and where loved ones can be involved more easily. If you live in a nursing home or assisted living facility, hospice care is provided in those locations as well. On occasion, an individual may choose to go to an inpatient facility to receive intensive hospice care focused on treating pain or other symptoms that cannot be treated in their home environment. Once these symptoms are under control, an individual will usually return home.

If I choose hospice care, how will I pay for the services?

Medicare, Medicaid and most private insurance companies cover the costs of hospice care. Local hospices will work closely with you to identify possible sources of payment. Hospice, the ultimate expression of caring, support and love, has served millions of people of all income levels, races, creeds, ages and medical circumstances. Hospice is here to help you when needed.



Can a hospice patient who shows signs of recovery be returned to regular medical treatment?

Yes. If the individual's condition seems to improve, the patient can be discharged from hospice and return to aggressive therapy or go on about his or her daily life. If a discharged patient should later need to return to hospice care, Medicare and most private insurance policies allow additional coverage for this purpose.

What does the hospice admission process involve?

One of the first things hospice will do is to contact the patient's physician to make sure he or she agrees that hospice care is appropriate for this patient at this time. If an individual does not have a physician, hospices may have medical staff available to help determine eligibility. Once a patient is identified as appropriate for hospice care, he or she will be asked to sign consent and insurance forms. These are similar to the forms patients sign when they enter a hospital.

Isn't hospice care just for people who have cancer?

No. Hospice care is available for patients with many terminal illnesses such as amyotrophic lateral sclerosis (ALS), dementia, heart disease, HIV/AIDS, liver disease, pulmonary disease, stroke, coma and other conditions. Inquire at your local hospice to learn more.

How do I make the hospice choice?

Speak to your physician, clergy, hospital discharge planner, social worker, nurse or local/state hospice organization. When you and your family realize that care, instead of cure, is most important to you, that is when to ask for hospice.

If I want to make the hospice choice and need more information about Ohio's hospices, who can help me?

The Midwest Care Alliance, whose mission is to promote the development and delivery of highest quality, end of life care through advocacy of hospice philosophy and standards, can provide this information. Call 800-776-9513 or visit www.midwestcarealliance.org

