

***Advance Directive for Iowa***

***(Durable Power of Attorney for Healthcare)***

**Introduction**

I have completed this Advance Directive with much thought. This document gives my treatment choices and preferences, and/or appoints a Health Care Agent (Durable Power of Attorney for Healthcare) to speak for me if I cannot communicate or make my own health care decisions. My Health Care Agent, if named, is able to make medical decisions for me, including the decision to refuse treatments that I do not want.

**Any advance directive document created before this is no longer legal or valid.**

My name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My telephone numbers: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My initials here indicate a professional medical interpreter helped me complete this document.

**Part 1: My Health Care Agent**

If the attending physician determines that I cannot make my own health care decisions, I choose the following person to communicate my wishes and make my health care decisions. My Health Care Agent must:

* Follow my health care instructions in this document.
* Follow any other health care instructions I have given to him or her.
* Make decisions in my best interest.

**I appoint:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone numbers: (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

as my attorney in fact (my agent) and give to my agent the power to make health care decisions for me. This power exists only when I am unable, in the judgement of my attending physician, to make those health care decisions. The attorney in fact must act consistently with my desires as stated in this document or otherwise made known.

Except as otherwise specified in this document, this document gives my agent the power, where otherwise consistent with the laws of the State of Iowa, to consent to my physician not giving health care or stopping health care which is necessary to keep me alive.

This document gives my agent power to make health care decisions on my behalf, including to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of my desires and any limitations included in this document.

I hereby revoke all prior Advance Directives, also known as Durable Power of Attorney for Healthcare.

OPTIONAL - If the person designated as agent above is unable to serve, I designate the following person to serve instead:

**My Alternate Health Care Agent is:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone numbers: (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Full address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Powers of my Health Care Agent:**

My Health Care Agent automatically has all the following powers when I am unable, in the judgement of my attending physician, to make health care decisions:

A. Agree to, refuse, or cancel decisions about my health care. This includes tests, medications, surgery, taking out or not putting in tube feedings, and other decisions related to treatments. If treatment has already begun, my agent can continue it or stop it based on my instructions.

B. Interpret any instruction in this document based on his or her understanding of my wishes, values and beliefs.

C. Request, receive, and review any information regarding my physical and mental health, including “protected health information” as defined by the Federal Health Insurance Portability and Accountability Act (HIPAA). I designate my agent as my “personal representative” with all the authority granted to such under HIPAA and applicable state and federal laws.

D. Arrange for my health care and treatment in Iowa or other state or location he or she thinks is appropriate.

E. Decide which health care providers and organizations provide my health care.

F. Make decisions about organ and tissue donation and autopsy according to my instructions in Part 2 of this document.

Comments or limits on the above:

**Additional powers of my Health Care Agent**:

My initials below indicate I also authorize my Health Care Agent to:

 Make decisions about the care of my body after death.

**OPTION 1**: I have entered into contract for prearranged funeral services of funeral merchandise as defined in and accepted under Iowa Code Chapter 523A. The contract may be found at .

**OPTION 2**: I own or have reserved a cemetery lot at .

In the event I am pregnant, decide whether to try to continue my pregnancy to delivery based upon my agent’s understanding of my values, preferences and/or instructions.

**Part 2: My Health Care Instructions**

My choices and preferences for health care are as follows. I ask my Health Care Agent to communicate these choices, and my health care team to honor them, if I cannot communicate or make my own choices. **I have initialed a box below for the option I prefer for each situation.**

***NOTE****: You do not need to write instructions about treatments to extend your life, but it is helpful to do so. If you do not have written instructions, your agent will make decisions based on your spoken wishes, or in your best interest if your wishes are unknown.*

**1. Cardiopulmonary Resuscitation: A Decision for the Present**

This decision refers to a treatment choice I am making today based on my current health. Item 3 below (**Treatments to Prolong My Life: A Decision for the Future**) indicates treatment choices I want if my health changes in the future and I cannot communicate for myself.

**CPR** is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. CPR may include chest compressions (forceful pushing on the chest to make the blood circulate), medications, electrical shocks, a breathing tube, and hospitalization**.** I understand that CPR can save a life but does not always work. I also understand that CPR does not work as well for people who have chronic (long-term) diseases or impaired functioning, or both. I understand that recovery from CPR can be painful and difficult.

Therefore:

I want CPR attempted if my heart or breathing stops.

***or***

I want CPR attempted if my heart or breathing stops based on my current state of health. However, in the future if my health has changed; for example:

* I have an incurable illness or injury and am dying
* I have no reasonable chance of survival if my heart or breathing stops
* I have little chance of long-term survival if my heart or breathing stops and CPR would cause significant suffering

then my agent or I (if I am able) should discuss CPR with my health care team. My choices in **Section 2: Treatment Preferences** and **Section 3: Treatments to Prolong My Life** below should be considered when making this decision.

***or***

I do not want CPR attempted if my heart or breathing stops. I want to allow a natural death. I understand if I choose this option I should see my health care provider about writing a Do Not Resuscitate (DNR) order.

**2. Treatment Choices: My Health Condition**

My treatment choices for my specific health condition(s) are written here. With any treatment choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

*My initials here indicate additional documents are attached. These documents have also been signed and witnessed:*

**3. Treatments to Prolong My Life: A Decision for the Future**

**If I can no longer make decisions for myself, and my health care team and agent believe I will not recover my ability to know who I am, I want:**

**NOTE:** With either choice, I understand I will continue to receive pain and comfort medicines, as well as food and liquids by mouth if I am able to swallow.

To **stop or withhold all treatments** that extend my life. This includes but is not limited to tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), and antibiotics. This may include hospice and/or palliative care for purposes of comfort.

***or***

**All treatments** **recommended** by my health care team. This includes but is not limited to tube feedings, IV (intravenous) fluids, respirator/ventilator (breathing machine), cardiopulmonary resuscitation (CPR), and antibiotics. I want treatments to continue until my health care team and agent agree such treatments are harmful or no longer helpful.

Comments or directions to my health care team:

**4. Organ donation**

I want to donate my eyes, tissues and/or organs, if able. My Health Care Agent, according to Iowa Law, may start and continue treatments or interventions needed to maintain my organs, tissues and eyes until donation has been completed, in accordance with Iowa Code Chapter 142C. This may prolong my life by days. My specific wishes (if any) are:

\*If you checked that you would like to donate your organs, register in your state at [www.DonateLife.net](http://www.DonateLife.net) to make your preferences known.

***or***

I do not want to donate my eyes, tissues and/or organs.

***or***

My Health Care Agent can decide.

**5. Autopsy**

My Health Care Agent may request an autopsy if the autopsy can help others understand the cause of my death or help with future health care decisions.

***or***

I do not want an autopsy unless required by law.

**6. Comments or directions to my health care team:**

*You may use this space to write any additional instructions or messages to your health care team which have not been covered in this directive, or to elaborate on a point for clarification. You may also leave this space blank.*

**7. If I need help to remain living independently, here are my wishes:**

**8. If I need comfort care which may include hospice, here are my wishes:**

*My initials here indicate additional documents are attached. These documents have also been signed and witnessed:*

**Part 3: My Hopes and Wishes**

I want my loved ones to know my following thoughts and feelings:

**The things that make life most worth living to me are:**

**My beliefs about when life would be no longer worth living:**

**What it would mean for me to be ready to die:**

**My thoughts and feelings about how and where I would like to die:**

**If I am nearing my death, I want my loved ones to know that I would appreciate the following for comfort and support** (rituals, prayers, music, etc.):

**Religious affiliation:** I am of the \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ faith, and am a member of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ faith community in (city) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Please notify them of my death and arrange for them to provide my funeral/memorial/burial. I would like my funeral to include, if possible, the following (people, music, rituals, etc.):

**Other wishes and instructions:**

*My initials here indicate additional documents are attached. These documents have also been signed and witnessed:*

**Part 4: Legal Authority**

***NOTE:*** *Under Iowa law, two witnesses* ***or*** *a notary public must verify your signature and the date. Your witnesses or notary public cannot be named as your primary or alternate Health Care Agent.*

I have made this document willingly. I am thinking clearly. This document states my wishes about my future health care decisions:

**Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If I cannot sign my name, I ask the following person to sign for me:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Printed Name Signature** *(of person asked to sign)*

**Statement of Witnesses:**

We, the undersigned, hereby state that we signed this document in the presence of each other and the Declarant/Principal and we witnessed the signing of the document by the Declarant/Principal or by another person acting on behalf of the Declarant/Principal at the direction of the Declarant/Principal. We state that:

* Neither of us is appointed as attorney in fact by this document
* Neither of us are health care providers who are presently treating the Declarant/Principal, or employees of such a health care provider.
* We are both at least 18 years of age.
* At least one of us is not related to the Declarant/Principal by blood, marriage or adoption.

**Witness 1:**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (optional) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Witness 2:**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address (optional) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Or***

**Notary Public:**

In the state of Iowa, County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

In my presence on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date), \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name)

acknowledged his or her signature on this document or that he or she authorized the person signing this document to sign on his or her behalf. I am not named as a Health Care Agent in this document.

*Signature of notary: Notary stamp:*

*My commission expires (date):*

**Part 5: Next Steps**

Now that I have completed my Advance Directive, I will also:

* Tell my primary and alternate Health Care Agents and make sure they feel able to do this important job for me in the future.
* Give my primary and alternate Health Care Agents a copy of this completed Advance Directive.
* Talk to the rest of my family and close friends who might be involved if I have a serious illness or injury, making sure they know who my Health Care Agent is, and what my wishes are.
* Give a copy of this completed Advance Directive to my doctor and other health care providers, and make sure they understood and will follow my wishes.
* Keep a copy of my Advance Directive where it can be easily found.
* Take a copy of my Advance Directive any time I am admitted to a health care facility, and ask that it be placed in my medical record.
* **Review my health care wishes every time I have a physical exam or whenever any of the “Five Ds” occur**:

**Decade** when I start each new decade of my life.

**Death** when I experience the death of a loved one.

**Divorce** when I experience a divorce or other major family change.

**Diagnosis** when I am diagnosed with a serious health condition.

**Decline** when I experience a significant decline or deterioration of an existing health condition, especially when I am unable to live on my own.

**Copies of this document have been given to:**

Primary (main) Health Care Agent (listed on page 1 of this document)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Alternate Health Care Agent (listed on page 1 of this document)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Care Provider/Clinic

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If my wishes change, I will fill out a new Advance Directive. I will give copies of the new document to everyone who has copies of my previous Advance Directive. I will tell them to destroy the previous version.**