

# ADVANCE DIRECTIVES INFORMATION PACKET



Healthcare Representative

Living Will Declaration

Life-Prolonging Procedures Declaration

Out of Hospital "Do Not Resuscitate"

Organ and Tissue Donation

Healthcare Treatment Directive

Psychiatric Advance Directive

Power of Attorney



**Decatur County  
Memorial Hospital**

The Quality Care You Want. Close By.

720 North Lincoln Street  
Greensburg, Indiana 47240

812-663-4331

[www.dcmh.net](http://www.dcmh.net)



# Indiana State Department of Health

2 North Meridian Street  
Indianapolis, Indiana 46204

March 1999  
Revised May 2004

---

## **ADVANCE DIRECTIVES**

### **YOUR RIGHT TO DECIDE**

---

The purpose of this brochure is to inform you of ways that you can direct your medical care and treatment in the event that you are unable to communicate for yourself. This brochure covers:

- What is an advance directive?
- Are advance directives required?
- What happens if you do not have an advance directive?
- What are the different types of advance directives?

## **THE IMPORTANCE OF ADVANCE DIRECTIVES**

Each time you visit your physician, you make decisions regarding your personal health care. You tell your doctor (generally referred to as a “physician”) about your medical problems. Your physician makes a diagnosis and informs you about available medical treatment. You then decide what treatment to accept. That process works until you are unable to decide what treatments to accept or become unable to communicate your decisions. Diseases common to aging such as dementia or Alzheimer’s disease may take away your ability to decide and communicate your health care wishes. Even young people can have strokes or accidents that may keep them from making their own health care decisions. Advance directives are a way to manage your future health care when you cannot speak for yourself.

## **WHAT IS AN ADVANCE DIRECTIVE?**

“Advance directive” is a term that refers to your spoken and written instructions about your future medical care and treatment. By stating your health care choices in an advance directive, you help your family and physician understand your wishes about your medical care. Indiana law pays special attention to advance directives.

Advance directives are normally one or more documents that list your health care instructions. An advance directive may name a person of your choice to make health care choices for you when you cannot make the choices for yourself. If you want, you may use an advance directive to prevent certain people from making health care decisions on your behalf.

Your advance directives will not take away your right to decide your current health care. As long as you are able to decide and express your own decisions, your advance directives will not be used. This is true even under the most serious medical conditions. Your advance directive will only be used when you are unable to communicate or when your physician decides that you no longer have the mental competence to make your own choices.

## **ARE ADVANCE DIRECTIVES REQUIRED?**

Advance directives are not required. Your physician or hospital cannot require you to make an advance directive if you do not want one. No one may discriminate against you if you do not sign one. Physicians and hospitals often encourage patients to complete advance directive documents. The purpose of the advance directive is for your physician to gain information about your health care choices so that your wishes can be followed. While completing an advance directive provides guidance to your physician in the event that you are unable to communicate for yourself, you are not required to have an advance directive.

## **WHAT HAPPENS IF YOU DO NOT HAVE AN ADVANCE DIRECTIVE?**

If you do not have an advance directive and are unable to choose medical care or treatment, Indiana law decides who can do this for you. Indiana Code § 16-36 allows any member of your immediate family (meaning your spouse, parent, adult child, brother, or sister) or a person appointed by a court to make the choice for you. If you cannot communicate and do not have an advance directive, your physician will try to contact a member of your immediate family. Your health care choices will be made by the family member that your physician is able to contact.

## **WHAT TYPES OF ADVANCE DIRECTIVES ARE RECOGNIZED IN INDIANA?**

- Talking directly to your physician and family
- Organ and tissue donation
- Health care representative
- Living Will Declaration or Life-Prolonging Procedures Declaration
- Psychiatric advance directives
- Out of Hospital Do Not Resuscitate Declaration and Order
- Power of Attorney

## **TALKING TO YOUR PHYSICIAN AND FAMILY**

One of the most important things to do is to talk about your health care wishes with your physician. Your physician can follow your wishes only if he or she knows what your wishes are. You do not have to write down your health care wishes in an advance directive. By discussing your wishes with your physician, your physician will record your choices in your medical chart so that there is a record available for future reference. Your physician will follow your verbal instructions even if you do not complete a written advance directive. Solely discussing your wishes with your physician, however, does not cover all situations. Your physician may not be available when choices need to be made. Other health care providers would not have a copy of the medical records maintained by your physician and therefore would not know about any verbal instructions given by you to your physician. In addition, spoken instructions provide no written evidence and carry less weight than written instructions if there is a disagreement over your care. Writing down your health care choices in an advance directive document makes your wishes clear and may be necessary to fulfill legal requirements. If you have written advance directives, it is important that you give a copy to your physician. He or she will keep it in your medical chart.

If you are admitted to a hospital or health facility, your physician will write orders in your medical chart based on your written advance directives or your spoken instructions. For instance, if you have a fatal disease and do not want cardiopulmonary resuscitation (CPR), your physician will need to write a “do not resuscitate” (DNR) order in your chart. The order makes the hospital staff aware of your wishes. Because most people have several health care providers, you should discuss your wishes with all of your providers and give each provider a copy of your advance directives.

It is difficult to talk with family about dying or being unable to communicate. However, it is important to talk with your family about your wishes and ask them to follow your wishes. You do not always know when or where an illness or accident will occur. It is likely that your family would be the first ones called in an emergency. They are the best source of providing advance directives to a health care provider.

## **ORGAN AND TISSUE DONATION**

Increasing the quality of life for another person is the ultimate gift. Donating your organs is a way to help others. Making your wishes concerning organ donation clear to your physician and family is an important first step. This lets them know that you wish to be an organ donor. Organ donation is controlled by the Indiana Revised Uniform Anatomical Gift Act found at Indiana Code § 29-2-16.1. A person that wants to donate organs may include their choice in their will, living will, on a card, or other document. If you do not have a written document for organ donation, someone else will make the choice for you. A common method used to show that you are an organ donor is making the choice on your driver’s license. When you get a new or renewed license, you can ask the license branch to mark your license showing you are an organ donor.

## HEALTH CARE REPRESENTATIVE

A “health care representative” is a person you choose to receive health care information and make health care decisions for you when you cannot. To choose a health care representative, you must fill out an appointment of health care representative document that names the person you choose to act for you. Your health care representative may agree to or refuse medical care and treatments when you are unable to do so. Your representative will make these choices based on your advance directive. If you want, in certain cases and in consultation with your physician, your health care representative may decide if food, water, or respiration should be given artificially as part of your medical treatment.

Choosing a health care representative is part of the Indiana Health Care Consent Act, found at Indiana Code § 16-36-1. The advance directive naming a health care representative must be in writing, signed by you, and witnessed by another adult. Because these are serious decisions, your health care representative must make them in your best interest. Indiana courts have made it clear that decisions made for you by your health care representative should be honored.

## LIVING WILL

A “living will” is a written document that puts into words your wishes in the event that you become terminally ill and unable to communicate. A living will is an advance directive that lists the specific care or treatment you want or do not want during a terminal illness. A living will often includes directions for CPR, artificial nutrition, maintenance on a respirator, and blood transfusions. The Indiana Living Will Act is found at Indiana Code § 16-36-4. This law allows you to write one of two kinds of advance directive.

**Living Will Declaration:** This document is used to tell your physician and family that life-prolonging treatments should not be used so that you are allowed to die naturally. Your living will does not have to prohibit all life-prolonging treatments. Your living will should list your specific choices. For example, your living will may state that you do not want to be placed on a respirator but that you want a feeding tube for nutrition. You may even specify that someone else should make the decision for you.

**Life-Prolonging Procedures Declaration:** This document is the opposite of a living will. You can use this document if you want all life-prolonging medical treatments used to extend your life.

Both of these documents can be canceled orally, in writing, or by destroying the declaration yourself. The cancellation takes effect only when you tell your physician. For either of these documents to be used, there must be two adult witnesses and the document must be in writing and signed by you or someone that has permission to sign your name in your presence.

## PSYCHIATRIC ADVANCE DIRECTIVE

Any person may make a psychiatric advance directive if he/she has legal capacity. This written document expresses your preferences and consent to treatment measures for a specific diagnosis. The directive sets forth the care and treatment of a mental illness during periods of incapacity. This directive requires certain items in order for the directive to be valid. Indiana Code § 16-36-1.7 provides the requirements for this type of advance directive.

## OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

In a hospital or health facility setting, if you have a terminal condition and you do not want CPR, your physician will write a “do not resuscitate” order in your medical chart. However, if you are home when an emergency occurs, there is no medical chart or physician’s order. For situations outside of a hospital or health facility, the “Out of Hospital Do Not Resuscitate Declaration and Order” is used to state your wishes. The Out of Hospital Do Not Resuscitate Declaration and Order is found at Indiana Code § 16-36-5. For those outside of a hospital, law allows a qualified person to say they do not want CPR given if the heart or lungs stop working. This declaration may override other advance directives. The declaration may be canceled by you at any time by writing cancel or invalid on the “Out of Hospital Do Not Resuscitate” document and then sign and date it, or by destroying the document, or by communicating to health care providers at the scene the desire to cancel the order. Emergency Medical Services (EMS) may have procedures in place for marking your home so they know you have an order.

## POWER OF ATTORNEY

A “power of attorney” (also referred to as a “durable power of attorney”) is another kind of advance directive. This document is used to grant another person say-so over your affairs. Your power of attorney document may cover financial matters, give health care authority, or both. **The document provided in this booklet is regarding financial matters only.** By giving this power to another person, you give this person your power of attorney. The legal term for the person you choose is “attorney in fact.” Your attorney in fact does not have to be an attorney. Your attorney in fact can be any adult you trust. Your attorney in fact is given the power to act for you only in the ways that you list in the document. The document must:

1. Name the person you want as your attorney in fact;
2. List the situations which give the attorney in fact the power to act;
3. List the powers you want to give; and
4. List the powers you do not want to give.

The person you name as your power of attorney is not required to accept the responsibility. Prior to executing a power of attorney document, you should talk with the person to ensure that he or she is willing to serve. A power of attorney document may be used to designate a health care representative. Health care powers are granted in the power of attorney document by naming your attorney in fact as your health care representative under the Health Care Consent Act or by referring to the Living Will Act. When a power of attorney document is used to name a health care representative, this person is referred to as your health care power of attorney. A health care power of attorney generally serves the same role as a health care representative in a health care representative advance directive. Including health care powers could allow your attorney in fact to:

1. Make choices about your health care;
2. Sign health care contracts for you;
3. Admit or release you from hospitals or other health facilities;
4. Look at or get copies of your medical records; and
5. Do a number of other things in your name.

The Indiana Powers of Attorney Act is found at Indiana Code § 30-5. Your power of attorney document must be in writing and signed in the presence of a notary public. You can cancel a power of attorney at any time but only by signing a written cancellation and having the cancellation delivered to your attorney in fact.

If your intent is to allow your financial power of attorney to make property transactions on your behalf, then your completed document must be filed with the county recorder’s office.

## **WHICH ADVANCE DIRECTIVE OR DIRECTIVES SHOULD BE USED?**

The choice of advance directives depends on what you are trying to do. The advance directives listed above may be used alone or together. **Although an attorney is not required, you may want to talk with one before you sign an advance directive.** The laws are complex and it is always wise to talk to an attorney about questions and your legal choices. An attorney is often helpful in advising you on complex family matters and making sure that your documents are correctly done under Indiana law. An attorney may be helpful if you live in more than one state during the year. An attorney can advise you whether advance directives completed in another state are recognized in Indiana.

## **CAN I CHANGE MY MIND AFTER I WRITE AN ADVANCE DIRECTIVE?**

It is important to discuss your advance directives with your family and health care providers. Your health care wishes cannot be followed unless someone knows your wishes. You may change or cancel your advance directives at any time as long as you are of sound mind. If you change your mind, you need to tell your family, health care representative, power of attorney, and health care providers. You might have to cancel your decision in writing for it to become effective. Always be sure to talk directly with your physician and tell him or her your exact wishes.

## **ARE THERE FORMS TO HELP IN WRITING THESE DOCUMENTS?**

Advance directive forms are available from many sources. Most physicians, hospitals, health facilities, or senior citizen groups can provide you with forms or refer you to a source. These groups often have the information on their web sites. You should be aware that forms may not do everything you want done. Forms may need to be changed to meet your needs. Although advance directives do not require an attorney, you may wish to consult with one before you try to write one of the more complex legal documents listed above.

## **WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE IF I CHOOSE TO HAVE ONE?**

Make sure that your health care representative, immediate family members, physician, attorney, and other health care providers know that you have an advance directive. Be sure to tell them where it is located. You should ask your physician and other health care providers to make your advance directives part of your permanent medical chart. If you have a power of attorney, you should give a copy of your advance directives to your attorney in fact. You may wish to keep a small card in your purse or wallet that states that you have an advance directive, where it is located, and who to contact for your attorney in fact or health care representative, if you have named one.

## **FINAL THOUGHTS ABOUT ADVANCE DIRECTIVES**

- You have the right to choose the medical care and treatment you receive. Advance directives help make sure you have a say in your future health care and treatment if you become unable to communicate.
- Even if you do not have written advance directives, it is important to make sure your physician and family are aware of your health care wishes.
- No one can discriminate against you for signing, or not signing, an advance directive. An advance directive is, however, your way to control your future medical treatment.
- This information was prepared by the Indiana State Department of Health as an overview of advance directives. The Indiana State Department of Health attorneys cannot give you legal advice concerning living wills or advance directives. You should talk with your personal lawyer or representative for advice and assistance in this matter.

**Indiana State Department of Health  
2 North Meridian Street  
Indianapolis, Indiana 46204**

**<http://www.in.gov/isdh>**

**The remainder of this packet  
has been prepared by  
Decatur County Memorial Hospital.  
While maintaining legal content,  
forms and information have been adapted  
to meet the needs of the patients  
and families we serve.**

## PATIENT SELF-DETERMINATION ACT PATIENT INFORMATION PACKAGE

Decatur County Memorial Hospital and physicians thereof respect your wishes as a patient and your choices for medical treatment. You have the responsibility to tell your doctor of your wishes. As long as you are able, you will make these decisions with the help of your doctor. Unfortunately, during some illnesses, you may be unable to express your wishes—at the very time when many important decisions need to be made. In this situation it could be helpful to have some written instructions for your doctor to follow.

Federal law now requires that hospitals ask all adult patients if they have written instructions (Advance Directives) regarding their health care, such as a Living Will. If patients do not, hospitals must provide information to them about choices available under state law. The law does not require the patients to have written instructions, only that hospitals must ask.

If you wish to make some written instructions for health care providers to use should you become unable to communicate, you may complete any of the attached forms (listed below). You can change any of these forms at any time. Your choices will not change the quality of care you will receive. Unless you or these forms advise otherwise, you will receive care that is reasonable considering your condition at the time.

Indiana law recognizes the following Advance Directives:

1. **Appointment of Healthcare Representative.**
2. **The Living Will.**
3. **Life-Prolonging Procedures Declaration.**
4. **Out of Hospital “Do Not Resuscitate”.**
5. **Organ and Tissue Donation.**
6. **Psychiatric Advance Directive.**
7. **Power of Attorney.** *Someone with “power of attorney” does not have the power to make health care decisions unless this is specifically written in this document.*

Also included in this packet is a Healthcare Treatment Directive. This form has not been formally adopted by our legislature but can be used to help your family and health care providers understand what you desire.

Discuss all documents and your ideas about quality of life with your Healthcare Representative, physician(s), family members, friends and clergy, and provide them with a signed copy (or photocopy thereof) of each. You may revoke or change these documents. Periodic review is recommended. If there are no changes after each review, initial and date in the margin. Feel free, at any time, to bring your Advance Directive documents to Decatur County Memorial Hospital Health Information Department, where it will be filed.

When you are admitted to the hospital, you (or your family) should provide the hospital with a copy of any completed forms. You should also always provide your family and physician a copy of any completed forms. Please retain all originals for your records. The document must be on the medical record to be honored.

**WITNESSES (unless stated on form or otherwise) cannot be your parent(s), spouse, child/children, or persons who can benefit from your estate or who are financially responsible for you. Witness must be competent and at least eighteen year of age. Hospital employees may not witness signature of advance directives.**

**IF YOU NEED ASSISTANCE:** Contact a lawyer or the Agency on Aging has a paralegal who will assist senior citizens in preparing advance directives such as, living wills or appointment of a Healthcare Representative. If you are age 60 or older, or disabled, contact Roger Walby, Agency on Aging, at 1-866-644-6407. In addition, the Social Work Department at Decatur County Memorial Hospital is available to answer questions or assist anyone regarding advance directives by calling 812-663-1176.



**Indiana Law permits people  
to make advance directives in  
one of the following forms:**



**APPOINTMENT OF HEALTHCARE REPRESENTATIVE**

Patient Printed Name	Social Security #	Date of Birth
----------------------	-------------------	---------------

Pursuant to Indiana Code 16-36-1-7 et seq. I hereby appoint:

Printed Name of Healthcare Representative/Relationship	Printed Name of Healthcare Representative/Relationship
Address	Address
Telephone Number (       )	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.

My healthcare representative is authorized as follows:

Any statement in paragraphs 1 through 5 with which I do not agree, I have drawn a line through it and have added my initials.
---

1. Consent, refuse or withdraw consent to any care, treatment, service or procedure (including artificially supplied nutrition and/or hydration/tube feeding) used to maintain, diagnose or treat a physical or mental condition;
2. Make all necessary arrangements for any hospital, psychiatric hospital or psychiatric treatment facility, hospice, nursing home or similar institution; to employ or discharge health care personnel (any person who is licensed, certified or otherwise authorized or permitted by the laws of the state to administer health care) as the agent shall deem necessary for my physical, mental and emotional well being;
3. Request, receive and review any information, verbal or written, regarding my personal affairs or physical or mental health including medical and hospital records and to execute any releases of other documents that may be required in order to obtain such information;
4. Move me into or out of any state for the purpose of complying with my written Advance Directive(s) or the decision of my Healthcare Representative per my written Advance Directive;
5. Take any legal action necessary to do what I have directed.

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 healthcare representative.

Patient Signature	Date
Witness Signature	Printed Name
Witness Signature	Printed Name
	Date

**Acceptance Signature (optional):** I have discussed this document with the person appointing the Healthcare Representative and I accept responsibility designated to me as stated above.

Healthcare Representative Signature/Date	Healthcare Representative Signature/Date
--	--

**NOTE: Hospital employees may not witness signature.**







**LIFE-PROLONGING PROCEDURES DECLARATION**

**Indiana Code 16-36-4-11**

Declaration made this \_\_\_\_\_ day of \_\_\_\_\_ (month/year).

I, \_\_\_\_\_ being at least eighteen (18) years old and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition, I request the use of life-prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

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 request medical or surgical treatment and accept the consequences of the request.

I understand the full import of this declaration.

Printed Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Signed \_\_\_\_\_

Date \_\_\_\_\_

City, County, and State of Residence \_\_\_\_\_

The declarant has been personally known by me and I believe him/her to be of sound mind. I am competent and at least eighteen (18) years old.

Witness: \_\_\_\_\_

Date \_\_\_\_\_

Witness: \_\_\_\_\_

Date \_\_\_\_\_

**NOTE: Hospital employees may not witness signature.**





**Out of Hospital “Do Not Resuscitate” (DNR)**

It is possible for you to obtain an out of Hospital “Do Not Resuscitate” Order.

If:

- a. You have a terminal condition that will result in death within a short period; or
- b. You have a medical condition that would result in resuscitation being unsuccessful or you likely would experience repeated cardiac or pulmonary failure resulting in death.

This document will not take effect if you are pregnant. Without such an order, emergency personnel are obligated to take all possible steps including CPR, even if the effort is excessively burdensome or futile.

If you obtain an Out of Hospital DNR order, it is recommended you do obtain an ID bracelet or necklace to wear that will alert emergency personnel of the order. The ID device should state, “DO NOT RESUSCITATE.” (These can be ordered through your local pharmacy.)

Place the document in your refrigerator along with a magnet on your refrigerator that identifies you have such an order, DO NOT RESUSCITATE. This will allow for easy identification of the existence of an order and easy access to the document by emergency personnel. Both the magnet and a blue waterproof envelope are available at our volunteer desk.

**Out of Hospital Do Not Resuscitate Declaration and Order**

**Indiana Code 16-36-5-6**

This Declaration and Order is effective on the date of execution and remains in effect until death of the declarant or revocation.

**Out of Hospital Do Not Resuscitate Declaration**

Made this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, 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:

My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital or a health facility, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this Out of Hospital DNR Declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this Declaration.

I understand the full import of this declaration.

Signature of Declarant: \_\_\_\_\_ Printed Name: \_\_\_\_\_  
Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
\_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

The declarant, \_\_\_\_\_, has been personally known to me, and I believe the declarant 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 years of age.

\_\_\_\_\_  
Witness Signature Printed Name Date

\_\_\_\_\_  
Witness Signature Printed Name Date

**Out of Hospital Do Not Resuscitate Order (Physician)**

I, \_\_\_\_\_, the attending physician of \_\_\_\_\_, certify the declarant as a qualified person to make an Out of Hospital DNR Declaration and I order health care providers having actual notice of this Out of Hospital DNR Declaration not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless this Out of Hospital DNR Declaration is revoked.

\_\_\_\_\_  
Physician Signature Date

\_\_\_\_\_  
Physician Printed Name Medical License No.

## ORGAN AND TISSUE DONATION

Indiana Code 29-2-16.1

Indiana Organ Procurement Organization, Inc. (IOPO) is a not-for-profit agency dedicated to furthering organ, tissue and eye donation throughout Indiana. IOPO coordinates organ donation with Indiana donor families, transplant teams, donor and recipient hospitals and recipient families.

Please review this information about organ, tissue and cornea donation and make your personal decision. Discuss your wishes with your family because, even if you have signed your driver's license or a donor card indicating that you wish to be a donor, your next-of-kin will likely be asked for consent for donation at the time of your death. Even though, by law, family consent is no longer required, IOPO likely will talk with your family and abide by their wishes. Knowing your wishes can be a great comfort to your family during a difficult time.

Almost anyone from birth to age 75 and beyond can be a donor.

A total donor wishes to donate all usable organs and tissues. A partial donor chooses to donate only selected organs and tissues. Following are organs and tissues you can choose to donate:

### **ORGANS**

Kidney  
Liver  
Lung  
Pancreas  
Heart  
Intestine

### **TISSUES**

Cornea/Eye  
Bone  
Tendons  
Heart  
Valves  
Skin  
Veins

At the time of your death, your ability to donate will be determined by IOPO. All cost related to the donation will be covered by the organ and tissue recovering agencies. There is no change to the donor's appearance or to customary funeral arrangements.

IOPO, tissue and eye banks are not directly involved in the recovery of the body for total body donation to medical science. Individuals wishing to donate their bodies to science may contact the organization listed below. An individual can be a cornea/eye donor and also a total body donor. **However, total body donation precludes any organ or tissue donation.** Bodies of deceased persons donated under the ANATOMICAL GIFT ACT are donated to the Anatomical Education Program of the Indiana University School of Medicine. This program is responsible for assigning the body to a teaching institution.

PRIOR ARRANGEMENTS for the donation of the body upon death for Medical Science Research must be made by contacting the

ANATOMICAL EDUCATION PROGRAM OF THE  
INDIANA UNIVERSITY SCHOOL OF MEDICINE  
(317) 274-7450

## ORGAN AND TISSUE DONATION

If your wishes are to become a donor at the time of your death, discuss your wishes with your family and sign the card below. A copy should be provided to your family, physician, and hospital.

In hope that I may help others:

I, \_\_\_\_\_, have discussed organ, tissue and eye donation with my family. I wish to donate:

- any organs, tissue or corneas  
 only the following organs and tissues: \_\_\_\_\_  
 my body for study (medical research or education)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security #

\_\_\_\_\_  
Date of Birth

The following relatives have witnessed my commitment to be a donor:

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relation

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Relation

**NOTE: Hospital employees may not witness signature.**

If you have questions about donation, please write:

Indiana Organ Procurement  
Organization, Inc.  
429 N. Pennsylvania Street, Suite 201  
Indianapolis, IN 46204-1816

or call: 1-888-ASK-IOPO (275-4676)

or visit: [www.IOPO.org](http://www.IOPO.org).

If you would like to donate your body to science or if you have questions, call the Anatomical Education Program of the Indiana University School of Medicine at 317-274-7450. This **MUST** be arranged prior to your death.



**INDIANA GENERAL DURABLE POWER OF ATTORNEY**

**THE POWERS YOU GRANT BELOW ARE EFFECTIVE  
EVEN IF YOU BECOME DISABLED OR INCOMPETENT**

NOTICE: THE POWERS GRANTED BY THIS DOCUMENT ARE BROAD AND SWEEPING. THEY ARE EXPLAINED IN THE UNIFORM STATUTORY FORM POWER OF ATTORNEY ACT. IF YOU HAVE ANY QUESTIONS ABOUT THESE POWERS, OBTAIN COMPETENT LEGAL ADVICE. THIS DOCUMENT DOES NOT AUTHORIZE ANYONE TO MAKE MEDICAL AND OTHER HEALTH-CARE DECISIONS FOR YOU. YOU MAY REVOKE THIS POWER OF ATTORNEY IF YOU LATER WISH TO DO SO. THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE TO BE EFFECTIVE EVEN IF YOU BECOME DISABLED, INCAPACITATED, OR INCOMPETENT.

I \_\_\_\_\_ [insert your name and address]

appoint \_\_\_\_\_ [insert the name(s) and address(es) of the person appointed] as my Agent (attorney-in-fact) to act for me in any lawful way with respect to the following initialed subjects:

TO GRANT THE FOLLOWING POWERS, INITIAL THE LINE **IN FRONT** OF EACH POWER YOU ARE GRANTING.

TO WITHHOLD A POWER, DO NOT INITIAL THE LINE IN FRONT OF IT. YOU MAY, BUT NEED NOT, CROSS OUT EACH POWER WITHHELD.

**Note: If you initial Item A or Item B, which follow, a notarized signature will be required on behalf of the Principal.**

INITIAL

\_\_\_\_\_ **(A) Real property transactions.** To lease, sell, mortgage, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, sale, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any interest in real property whatsoever, on such terms and conditions, and under such covenants, as my Agent shall deem proper; and to maintain, repair, tear down, alter, rebuild, improve manage, insure, move, rent, lease, sell, convey, subject to liens, mortgages, and security deeds, and in any way or manner deal with all or any part of any interest in real property whatsoever, including specifically, but without limitation, real property lying and being situated in the State of Indiana, under such terms and conditions, and under such covenants, as my Agent shall deem proper and may for all deferred payments accept purchase money notes payable to me and secured by mortgages or deeds to secure debt, and may from time to time collect and cancel any of said notes, mortgages, security interests, or deeds to secure debt.

\_\_\_\_\_ **(B) Tangible personal property transactions.** To lease, sell, mortgage, purchase, exchange, and acquire, and to agree, bargain, and contract for the lease, sale, purchase, exchange, and acquisition of, and to accept, take, receive, and possess any personal property whatsoever, tangible or intangible, or interest thereto, on such terms and conditions, and under such covenants, as my Agent shall deem proper; and to maintain, repair, improve, manage, insure, rent, lease, sell, convey, subject to liens or mortgages, or to take any other security interests in said property which are recognized under the Uniform Commercial Code as adopted at that time under the laws of the State of Indiana or any applicable state, or otherwise hypothecate (pledge), and in any way or manner deal with all or any part of any real or personal property whatsoever, tangible or intangible, or any interest therein, that I own at the time of execution or may thereafter acquire, under such terms and conditions, and under such covenants, as my Agent shall deem proper.

\_\_\_\_\_ **(C) Stock and bond transactions.** To purchase, sell, exchange, surrender, assign, redeem, vote at any meeting, or otherwise transfer any and all shares of stock, bonds, or other securities in any business, association, corporation, partnership, or other legal entity, whether private or public, now or hereafter belonging to me.

\_\_\_\_\_ **(D) Commodity and option transactions.** To organize or continue and conduct any business which term includes, without limitation, any farming, manufacturing, service, mining, retailing or other type of business operation in any form, whether as a proprietorship, joint venture, partnership, corporation, trust or other legal entity; operate, buy, sell, expand, contract, terminate or liquidate any business; direct, control, supervise, manage or participate in the operation of any business and engage, compensate and discharge business managers, employees, agents, attorneys, accountants and consultants; and, in general, exercise all powers with respect to business interests and operations which the principal could if present and under no disability.

\_\_\_\_\_ **(E) Banking and other financial institution transactions.** To make, receive, sign, endorse, execute, acknowledge, deliver and possess checks, drafts, bills of exchange, letters of credit, notes, stock certificates, withdrawal receipts and deposit instruments relating to accounts or deposits in, or certificates of deposit of banks, savings and loans, credit unions, or other institutions or associations. To pay all sums of money, at any time or times, that may hereafter be owing by me upon any account, bill of exchange, check, draft, purchase, contract, note, or trade acceptance made, executed, endorsed, accepted, and delivered by me or for me in my name, by my Agent. To borrow from time to time such sums of money as my Agent may deem proper and execute promissory notes, security deeds or agreements, financing statements, or other security instruments in such form as the lender may request and renew said notes and security instruments from time to time in whole or in part. To have free access at any time or times to any safe deposit box or vault to which I might have access.

\_\_\_\_\_ **(F) Business operating transactions.** To conduct, engage in, and otherwise transact the affairs of any and all lawful business ventures of whatever nature or kind that I may now or hereafter be involved in.

\_\_\_\_\_ **(G) Insurance and annuity transactions.** To exercise or perform any act, power, duty, right, or obligation, in regard to any contract of life, accident, health, disability, liability, or other type of insurance or any combination of insurance; and to procure new or additional contracts of insurance for me and to designate the beneficiary of same; provided, however, that my Agent cannot designate himself or herself as beneficiary of any such insurance contracts.

\_\_\_\_\_ **(H) Estate, trust, and other beneficiary transactions.** To accept, receipt for, exercise, release, reject, renounce, assign, disclaim, demand, sue for, claim and recover any legacy, bequest, devise, gift or other property interest or payment due or payable to or for the principal; assert any interest in and exercise any power over any trust, estate or property subject to fiduciary control; establish a revocable trust solely for the benefit of the principal that terminates at the death of the principal and is then distributable to the legal representative of the estate of the principal; and, in general, exercise all powers with respect to estates and trusts which the principal could exercise if present and under no disability; provided, however, that the Agent may not make or change a will and may not revoke or amend a trust revocable or amendable by the principal or require the trustee of any trust for the benefit of the principal to pay income or principal to the Agent unless specific authority to that end is given.

\_\_\_\_\_ **(I) Claims and litigation.** To commence, prosecute, discontinue, or defend all actions or other legal proceedings touching my property, real or personal, or any part thereof, or touching any matter in which I or my property, real or personal, may be in any way concerned. To defend, settle, adjust, make allowances, compound, submit to arbitration, and compromise all accounts, reckonings, claims, and demands whatsoever that now are, or hereafter shall be, pending between me and any person, firm, corporation, or other legal entity, in such manner and in all respects as my Agent shall deem proper.

\_\_\_\_\_ **(J) Personal and family maintenance.** To hire accountants, attorneys at law, consultants, clerks, physicians, nurses, agents, servants, workmen, and others and to remove them, and to appoint others in their place, and to pay and allow the persons so employed such salaries, wages, or other remunerations, as my Agent shall deem proper.

\_\_\_\_\_ **(K) Benefits from Social Security, Medicare, Medicaid, or other governmental programs, or military service.** To prepare, sign and file any claim or application for Social Security, unemployment or military service benefits; sue for, settle or abandon any claims to any benefit or assistance under any federal, state, local or foreign statute or regulation; control, deposit to any account, collect, receipt for, and take title to and hold all benefits under any Social Security, unemployment, military service or other state, federal, local or foreign statute or regulation; and, in general, exercise all powers with respect to Social Security, unemployment, military service, and governmental benefits, including but not limited to Medicare and Medicaid, which the principal could exercise if present and under no disability.

\_\_\_\_\_ **(L) Retirement plan transactions.** To contribute to, withdraw from and deposit funds in any type of retirement plan (which term includes, without limitation, any tax qualified or nonqualified pension, profit sharing, stock bonus, employee savings and other retirement plan, individual retirement account, deferred compensation plan and any other type of employee benefit plan); select and change payment options for the principal under any retirement plan; make rollover contributions from any retirement plan to other retirement plans or individual retirement accounts; exercise all investment powers available under any type of self-directed retirement plan; and, in general, exercise all powers with respect to retirement plans and retirement plan account balances which the principal could if present and under no disability.

\_\_\_\_\_ **(M) Tax matters.** To prepare, to make elections, to execute and to file all tax, social security, unemployment insurance, and informational returns required by the laws of the United States, or of any state or subdivision thereof, or of any foreign government; to prepare, to execute, and to file all other papers and instruments which the Agent shall think to be desirable or necessary for safeguarding of me against excess or illegal taxation or against penalties imposed for claimed violation of any law or other governmental regulation; and to pay, to compromise, or to contest or to apply for refunds in connection with any taxes or assessments for which I am or may be liable.

**SPECIAL INSTRUCTIONS:**

ON THE FOLLOWING LINES YOU MAY GIVE SPECIAL INSTRUCTIONS LIMITING OR EXTENDING THE POWERS GRANTED TO YOUR AGENT.

---

---

---

(YOUR AGENT WILL HAVE AUTHORITY TO EMPLOY OTHER PERSONS AS NECESSARY TO ENABLE THE AGENT TO PROPERLY EXERCISE THE POWERS GRANTED IN THIS FORM, BUT YOUR AGENT WILL HAVE TO MAKE ALL DISCRETIONARY DECISIONS. IF YOU WANT TO GIVE YOUR AGENT THE RIGHT TO DELEGATE DISCRETIONARY DECISION-MAKING POWERS TO OTHERS, YOU SHOULD KEEP THE NEXT SENTENCE, OTHERWISE IT SHOULD BE STRICKEN.)

**Authority to Delegate.** My Agent shall have the right by written instrument to delegate any or all of the foregoing powers involving discretionary decision-making to any person or persons whom my Agent may select, but such delegation may be amended or revoked by any agent (including any successor) named by me who is acting under this power of attorney at the time of reference.

(YOUR AGENT WILL BE ENTITLED TO REIMBURSEMENT FOR ALL REASONABLE EXPENSES INCURRED IN ACTING UNDER THIS POWER OF ATTORNEY. STRIKE OUT THE NEXT SENTENCE IF YOU DO NOT WANT YOUR AGENT TO ALSO BE ENTITLED TO REASONABLE COMPENSATION FOR SERVICES AS YOUR AGENT.)

**Right to Compensation.** My Agent shall be entitled to reasonable compensation for services rendered as agent under this power of attorney.

(IF YOU WISH TO NAME SUCCESSOR AGENTS, INSERT THE NAME(S), ADDRESS(ES) AND TELEPHONE NUMBER(S) OF SUCH SUCCESSOR(S) IN THE FOLLOWING PARAGRAPH.)

**Successor Agent.** If any Agent named by me shall die, become incompetent, resign or refuse to accept the office of Agent, I name the following (each to act alone and successively, in the order named) as successor(s) to such Agent:

---

---

---

**Choice of Law.** THIS POWER OF ATTORNEY WILL BE GOVERNED BY THE LAWS OF THE STATE OF INDIANA WITHOUT REGARD FOR CONFLICTS OF LAWS PRINCIPLES. IT WAS EXECUTED IN THE STATE OF INDIANA AND IS INTENDED TO BE VALID IN ALL JURISDICTIONS OF THE UNITED STATES OF AMERICA AND ALL FOREIGN NATIONS.

---

LIABILITY AND INDEMNITY: My attorney-in-fact shall only be liable for actions undertaken in bad faith; provided, however, my attorney-in-fact shall be liable for the negligent exercise of the powers described herein if the exercise of such power involves self-dealing. I hereby ratify and confirm all that my attorney-in-fact shall do by virtue hereof. Further, I agree to indemnify and hold harmless any person who, in good faith, acts under this Power of Attorney or transacts business with my attorney-in-fact in reliance upon this Power, without actual knowledge of its revocation.

THIS POWER OF ATTORNEY IS EFFECTIVE IMMEDIATELY AND WILL CONTINUE UNTIL IT IS REVOKED.

THIS POWER OF ATTORNEY SHALL BE CONSTRUED AS A GENERAL DURABLE POWER OF ATTORNEY AND SHALL CONTINUE TO BE EFFECTIVE EVEN IF I BECOME DISABLED, INCAPACITATED, OR INCOMPETENT.

---

### APPOINTMENT OF GUARDIAN OR CONSERVATOR

I designate \_\_\_\_\_  
[agent(s) name(s)], as my guardian(s) or conservator(s) should a guardianship or conservatorship be established for my person or property in order to implement any power intended by this document or for any other reason.

---

I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my Agent.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
[Your Signature]

\_\_\_\_\_  
[Your Social Security Number]

---

### CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC

STATE OF INDIANA: COUNTY OF \_\_\_\_\_

This document was acknowledged before me on \_\_\_\_\_ [Date] by  
\_\_\_\_\_ [name of principal].

[Notary Seal, if any]:

\_\_\_\_\_  
(Signature of Notarial Officer)

Notary Public for the State of Indiana

My commission expires: \_\_\_\_\_

---

### ACKNOWLEDGMENT OF AGENT

#### Acceptance Signature (optional)

BY ACCEPTING OR ACTING UNDER THE APPOINTMENT, THE AGENT ASSUMES THE FIDUCIARY AND OTHER LEGAL RESPONSIBILITIES OF AN AGENT.

\_\_\_\_\_  
[Financial Power of Attorney / Date]

\_\_\_\_\_  
[Financial Power of Attorney / Date]

## PSYCHIATRIC ADVANCE DIRECTIVE

Indiana Code § 16-36-1.7

The Indiana Health Care Consent statute<sup>1</sup> was recently amended to include a section creating a new type of advance directive – the psychiatric advance directive. A psychiatric advance directive (PAD) is a written instrument that expresses a person's preferences and consent regarding treatment measures to be implemented during periods when the person is incapacitated by mental illness. Such treatment measures include:

- (1) admission to an inpatient setting;
- (2) the administration of prescribed medication: orally or by injection;
- (3) physical restraint;
- (4) seclusion;
- (5) electroconvulsive therapy; or
- (6) mental health counseling.

**Requirements for Valid PAD.** In order to be valid, the PAD must be executed during a period when the person has capacity, as determined by the person's treating psychiatrist. The psychiatrist must sign the PAD and verify that the treatment preferences are appropriate. Because the treating psychiatrist's signature and attestations are required, patients who request to execute a PAD will need to be referred to their treating psychiatrists.

**Limitations of PAD.** There are certain limitations regarding the applicability of the PAD. The PAD does not apply when a person is involuntarily admitted to a facility on an immediate or emergency detention, or a temporary or regular commitment. The statute does not preclude an attending physician from treating the patient in a manner that is in the best interest of the patient or another individual.

---

<sup>1</sup> Indiana Code § 16-36

**PSYCHIATRIC ADVANCE DIRECTIVE**

Executed in accordance with Indiana Code § 16-36-1.7

1. Name and date of birth of the individual entering into the psychiatric advance directive:

\_\_\_\_\_

2. Name of the treatment program and the sponsoring facility or institution in which the individual is enrolled, if applicable:

\_\_\_\_\_

3. Individual's treating physician or other treating mental health personnel:

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

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

4. Treatment preferences of individual entering into this psychiatric advance directive for care and treatment of mental illness during periods of incapacity are checked below:

- admission to an inpatient setting;
- the administration of prescribed medication:
  - orally; and/or
  - by injection;
- physical restraint;
- seclusion;
- electroconvulsive therapy;
- mental health counseling.

5. Designated health care representative:

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

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

\_\_\_\_\_  
(Signature of the individual entering into the psychiatric advance directive)

Date on which individual signed the psychiatric advance directive: \_\_\_\_\_

**Attestation and Signature of Treating Psychiatrist**

I, \_\_\_\_\_, the treating psychiatrist for

(name of psychiatrist)

\_\_\_\_\_, hereby attest that:

(name of individual entering into the psychiatric advance directive)

- a. the treatment preferences stated in Section 4 above are appropriate; and
- b. at the time this psychiatric advance directive was executed,

\_\_\_\_\_ possessed capacity to enter into this  
(name of individual entering into psychiatric advance directive) psychiatric advance directive.

Signature of treating psychiatrist: \_\_\_\_\_ Date: \_\_\_\_\_

**The following advance directive has not been formally adopted by our legislature but can be used to help your family and health care providers understand what you desire.**



**HEALTH CARE TREATMENT DIRECTIVE**

I, \_\_\_\_\_, make this Health Care Treatment Directive to exercise my right to determine the course of my health care and to provide clear and convincing proof of my treatment decisions **when I lack the capacity to make or communicate my decisions** and there is no realistic hope that I will regain such capacity.

If my physician believes that a certain life prolonging procedure or other health care treatment may provide me with comfort, relieve pain or lead to a significant recovery, I direct my physician to try the treatment for a reasonable period of time. However, if such treatment proves to be ineffective, I direct treatment to be withdrawn even if so doing may shorten my life.

I direct I be given health care treatment to relieve pain or to provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit-forming.

**I understand if I have a terminal condition and do not want life prolonging procedures that I must also implement a Living Will to assure my wishes will be respected as permitted by Indiana law.**

I direct all life prolonging procedures to be withheld or withdrawn when there is no hope of significant recovery, and I have:

- substantial brain damage or brain disease which cannot be significantly reversed, or
- a condition, disease, or injury without reasonable expectation that I will regain an acceptable quality of life.

I describe a minimally acceptable quality of life for me as:

---

---

1. When any of the above conditions exist, **I DO NOT WANT** the life prolonging procedures which I have initialed below. (I understand any treatments not initialed may be administered to me.)

- Blood Products \_\_\_\_\_ initials
- Surgery \_\_\_\_\_ initials
- Heart-lung resuscitation (CPR) \_\_\_\_\_ initials
- Antibiotics \_\_\_\_\_ initials
- Kidney Dialysis \_\_\_\_\_ initials
- Mechanical Ventilator (respirator) \_\_\_\_\_ initials
- Artificially supplied hydration and nutrition –  
tube feedings (food and water delivered through  
a tube in the vein, nose or stomach.) \_\_\_\_\_ initials
- Other \_\_\_\_\_ initials

2. I make other instructions as follows:

---

---

---











# Decatur County Memorial Hospital

The Quality Care You Want. Close By.

720 North Lincoln Street  
Greensburg, Indiana 47240  
812.662.7500  
[www.dcmh.net](http://www.dcmh.net)