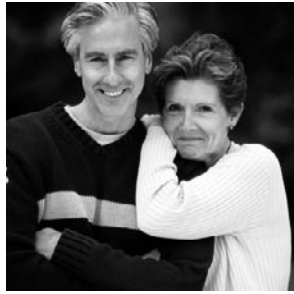


Advance Care Planning Guide

A process to think about, talk about and plan for life-threatening illness or end-of-life care



New Hampshire Advance Directives:
Durable Power of Attorney for
Health Care (DPOAH)
Living Will



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HEALTHY COMMUNITIES

www.healthynh.com

Why Advance Care Planning?

Making decisions about medical care is not always easy – especially now that machines can keep patients alive even when there is no hope for recovery. **It's your right to participate and plan for your care.** But at some point, you may become unable to make your own health care decisions. That's why it's important to think and talk about your feelings and beliefs with your loved ones – long before critical medical decisions must be made.

This guide provides you with information about creating an “advance directive document” – a legal document that states your preferences about medical care. Please read it carefully and discuss it with your family, doctor, nurse practitioner, patient representative, chaplain or other caregiver.

You don't need to have an advance directive document if you don't want one. No hospital, nursing home, doctor, nurse or insurance company can require you to have an advance directive document to provide you with services. However, it's a good idea to have an advance directive document in place if you want your family and health care providers to understand and follow your wishes about your medical care. It will also make it better for your family should you become unable to participate in decisions about your care. They will not have to guess about your choices, uncertain of what you would want them to do. And, if family members or your health care providers disagree about what is right for you, an advance directive document will help you avoid having decisions made by the probate court, which can be difficult, time consuming and costly.

NOTE: The first use of terms you may not understand have been indicated in italics and defined in the “Definitions” section at the end of this booklet.

Please note that these forms are not the same as NH statutes. You can obtain the statutory forms from NH Revised Statutes Annotated 137-J. The enclosed forms are substantially similar to NH statutes but written in simpler language. This guide was prepared based on New Hampshire law as it existed in January 2007 and printed to inform, not to advise. This is not intended to be a substitute for legal, medical, or other professional advice. Consult a trained expert for interpretation and application of current New Hampshire law. You may republish or cite any portion of this work, with the following attribution: “Reprinted by permission from the Foundation for Healthy Communities copyright © 2006. All rights reserved.” These materials may not be reproduced for resale.

Your thoughts or answers to these questions can help provide you and your caregivers with peace of mind.

VALUES

- What gives your life its purpose and meaning?
- What do you value most about your physical or mental well being? For example, do you love the outdoors? To read or listen to music? To be aware of who is with you?

FAMILY/FRIEND RELATIONSHIPS

- Who among your family and friends are important in your life?
- Have you talked about your medical care choices with your loved ones and with those who will be around you when problems arise or death comes close?

SPIRITUAL/RELIGIOUS BELIEFS

- How would you describe your spiritual or religious life?
- How does your faith community, church or synagogue support you?
- Do you have religious beliefs about medical treatment?

MEDICAL

- What health problems do you fear in the future?
- Under what conditions would you want the goals of medical treatment to change from trying to continue your life to focusing on your comfort?
- Would you want a *hospice* team or other form of *palliative care* offered to you?
- How does cost influence your decisions about medical care?
- How do you feel about *life-sustaining treatment*, such as kidney dialysis? Do you want *CPR* used to try to revive you if your heart stops or you stop breathing?

MAKING PLANS

- If you could plan it today, what would the last day or week of your life be like? Where would you be? Who would be with you?
- What will be important to you when you are dying (comfort, no pain, family present, music, prayer, being touched or held, etc.)?
- What general comments would you like to make about dying or death?
- Are you interested in *organ or tissue donation*?
- Are there people to whom you want to write a letter, or for whom you want to prepare a taped message, perhaps marked to be opened at a future time?
- What are your wishes for a memorial service: songs or readings you want, or people you hope will participate?
- Would you prefer to be buried or cremated, or do you have no preference? Have you contacted a funeral home?

Questions about advance directives

What are advance directives?

Advance directives are instructions you give regarding your future care. They may be oral or written. They may have been shared with family, friends, or medical providers. Family, friends and medical providers attempt to understand and fulfill your instructions, no matter what form they are in. However, to ensure that everyone understands your instructions, the State of New Hampshire recognizes a written advance directive document with two parts: a Durable Power of Attorney for Health Care and a Living Will.

What is a Durable Power of Attorney for Health Care (DPOAH)?

A Durable Power of Attorney for Health Care is a part of the advance directive document in which you name another person to act as your *health care agent* to make medical decisions for you if you become incapacitated. You can include instructions about which treatments you do or do not want, or how long you want to try possible treatments. If you do not want *medically administered feeding or hydration*, New Hampshire law requires that you say so in your document.

What is a Living Will?

A Living Will instructs your health care provider to give no life-sustaining treatment if you are *near death* or are *permanently unconscious*, without the hope of recovery. If you do not want medically administered feeding or hydration, New Hampshire law requires that you say so in your document.

Do I need both a Durable Power of Attorney for Health Care (DPOAH) and a Living Will?

It is a good idea to complete both parts of the advance directive document because they serve two different purposes. A DPOAH takes effect whenever you become unable to make decisions – for instance, during surgery, or even when you become temporarily unconscious. A Living Will takes effect only when there is no hope for recovery. Under New Hampshire law, if the terms of your advance directive conflict, the DPOAH will overrule the Living Will.

What is the difference between a DNR order and an advance directive?

In the event that your heart stops beating and you stop breathing, health care provider will normally perform *cardiopulmonary resuscitation (CPR)* to try to restart your breathing and heartbeat. However, if you are near death, you may decide that you do not want CPR performed. In this case, you may ask for a Do Not Attempt Resuscitation (DNR) order to be written. The differences between a DNR and an advance directive include: an advance directive is not a medical order, even though it is a legally recognized document, while a DNR order is a medical order; a DNR order applies only if your heart stops beating and you stop breathing, while an advanced directive deals with many other medical issues and decisions, such as whether to provide medically assisted feeding or hydration. You may want to include your wishes about DNR orders in your advance directive, in the event that you are not able to make your preference known in the future.

What if I want more than one person to make my health care decisions?

Many people want to designate more than one person to be their health care agent. For example, a person may want all three of their children to be responsible for their medical decisions. If you list more than one person as your health care agent, it is important to

know that the first person listed will be your decision-maker, followed by the next person listed, and so on. If you desire a different decision-making process (such as making sure all of your agents agree before a decision is made), you must make this clear in your advance directive.

How is it determined whether I am unable to make decisions about my medical care?

If the doctor or advanced registered nurse practitioner responsible for your care determines that you are unable to understand the significant risks and benefits of your health care decisions, they can document that you do not have “*capacity*”, in which case your health care agent, if you have designated one, will make decisions for you. This is not a permanent designation; if your doctor or ARNP later determines that you have regained capacity, you will be able to make your own health care decisions once again. If, when you do not have capacity to make medical decisions, you want the decisions of your health care agent to be followed even if you object to them, you must make that clear in your advance directive.

What doesn't the advance directive accomplish?

An advance directive only covers certain important health care issues. They do not provide for many other important personal planning or financial matters. A “Durable General Power of Attorney” is recommended for financial matters or other personal planning. You should discuss this and other non-health related issues with an attorney.

Are my old advance directive documents still valid?

Yes. An advance directive does not need to be renewed. However, if you want to change something in your advance directive document, you must complete a new one. You might want to re-examine your health care wishes from time to time. New Hampshire's Advance Directive law changed on January 1, 2007. However, if you have an advance directive document that was created before this date, it will still be honored under New Hampshire law.

Can I revoke my advance directive document?

You can revoke or cancel your advance directive document orally or in writing at any time. A separation, divorce, or marriage annulment action will automatically revoke your DPOAH if your spouse or partner is your health care agent and you have not named an alternate in your document. Additionally, if a protective order is filed between you and your health care agent, your DPOAH will also be automatically revoked if you have not named an alternate agent.

What if my advance directive document was *executed* in another state?

Your out-of-state advance directive is valid in New Hampshire as long as it was legally executed in the other state and is valid only in so much as it conforms to New Hampshire law.

Who should have copies of my advance directive document?

Copies of your documents should be with your doctor, your hospital, the person you select as your health care agent or long-term care facility and family. Ideally the original documents should be stored where you keep your other important legal papers such as wills, birth certificates and social security cards. This way you will always have quick access to these important directives.

How will my health care providers know I have an advance directive?

You should tell your doctor, nurses or other health care providers that you have an advance directive and provide them with a copy for your medical record. Any time you are admitted to a hospital, you will be asked if you have an advance directive. If you know that you will be admitted to a hospital, you should bring a copy of your document with you.

Do I need an attorney?

You do not need an attorney to create an advance directive document. You can simply use the form in this brochure, which is printed substantially similar to New Hampshire laws. However, if you have questions, you can talk with an attorney or trained staff from your community hospital or hospice. You can get the statutory forms from NH Revised Annotated Statutes 137-J.

Who can witness the signing of my advance directive document?

In order to be valid, your advance directive document can be signed **either** in the presence of two witnesses **or** a notary. Your health care agent named in your DPOAH, spouse, heir, *attending doctor or advanced registered nurse practitioner*, or person supervised by your doctor may not serve as a witness. Only one of the two witnesses may be your health or residential care provider or one of your provider's employees.

Why would I want to allow my health care agent to make decisions over my objection?

A DPOAH allows your health care agent to make decisions if you are unconscious or unable to communicate your wishes. A DPOAH may also be used to allow your agent to make decisions for you even if you are conscious and able to communicate, if your health care provider believes you lack capacity to make health decisions due to a condition that affects your cognitive or intellectual functioning, such as Alzheimer's disease, dementia or mental illness. When you sign your advance directive, you must decide whether or not to give up your right to object to your agent's decision about treatments. If you do not give up this right, treatment cannot be given or withheld over your objection. However you decide to answer the treatment against objection option, you can still decide to cancel your DPOAH at any time by deciding you want to change your choice of a health care agent.



*It's your right
to participate and plan for your care.*

Selecting Your Durable Power of Attorney for Health Care or Health Care Agent

When you decide to pick someone to speak for you in a medical crisis, in case you are not able to speak for yourself, there are several things to think about. The chart below is a tool to help you decide who the best person is. **Usually it is best to name one person or agent to serve at a time**, with at least one alternate, or back-up person, in case the first person is not available when needed.

Compare up to 3 people with this tool. The person best suited to be your DPOAH or Health Care Agent rates well on these qualifications ...

Name #1:		
Name #2:		
Name #3:		
		1. Meets the legal criteria in your state for acting as agent or representative? (This is a must! See page 7 – Disclosure.)
		2. Would be willing to speak on your behalf.
		3. Would be able to act on your wishes and separate his or her own feelings from yours.
		4. Lives close by or could travel to be at your side if needed.
		5. Knows you well and understands what’s important to you.
		6. Could handle the responsibility.
		7. Will talk with you now about sensitive issues and will listen to your wishes.
		8. Will likely be available long into the future.
		9. Would be able to handle conflicting opinions among family members, friends, and medical personnel.
		10. Can be a strong advocate in the face of an unresponsive doctor or institution.

This worksheet adapted by the American Bar Association’s Commission on Legal Problems of the Elderly from R. Pearlman, et. al., Your Life Your Choices – Planning for Future Medical Decisions: How to Prepare a Personalized Living Will, Veterans Administration Medical Center, Seattle, Washington. Reprinted by permission.

What to Do After you Pick a Health Care Agent

- Talk to your agent about the qualifications on this worksheet.
- Ask permission to name him or her as your agent.
- Discuss your health care wishes and values and fears with your agent and doctor or health provider.
- Make sure your agent and your doctor or health provider gets a copy of your advance directive.

“Making Medical Decisions for Someone Else: A New Hampshire Handbook” is a resource available at www.healthynh.com. It may also be available at the care facility where you receive healthcare.

Durable Power of Attorney for Health Care: Disclosure Statement

This is an important legal document. Before signing it, you should know these important facts:

Except if you say otherwise, this document gives the person you name as your health care agent the authority to make any and all health care decisions for you when you lack the capacity to make health care decisions for yourself (in other words, you no longer have the ability to understand and appreciate generally the nature and consequences of a health care decision, including the significant benefits and of and reasonable alternatives to any proposed health care.) "Health care" means any treatment, service or procedure to maintain, diagnose or treat your physical or mental condition.

Your health care agent, therefore, will have the power to make a wide range of health care decisions for you. Your health care agent may consent (in other words, give permission), refuse to consent or withdraw consent to medical treatment, and may make decisions about withdrawing or withholding life-sustaining treatment.



If you want to give your health care agent power to withhold or withdraw medically administered nutrition and hydration, you must say so in your document. Otherwise, your health care agent will not be able to direct that. Under no condition will your health care agent be able to direct the withholding of food and drink that you are able to eat and drink normally.

You may state in this document any treatment you do not want, or treatment you want to be sure you receive. Your health care agent's power will begin when your doctor or nurse practitioner certifies that you lack the capacity to make health care decisions (in other words, that you are not able to make health care decisions). You may attach additional pages to the directive if you need more space to complete your statement.

Your health care agent cannot consent to or direct any of the following: • commitment to a state institution; • sterilization; or • termination of treatment if you are pregnant and if the withdrawal of that treatment is deemed likely to terminate the pregnancy, unless the treatment will be physically harmful to you or prolong severe pain which cannot be alleviated by medication.

If, for moral or religious reasons, you do not want to be treated by a doctor or Advanced Registered Nurse Practitioner (ARNP) or to be examined by a doctor or ARNP to certify that you lack capacity, you must say so in the directive and you must name someone who can certify your lack of capacity. That person cannot be your health care agent or alternate health care agent, or any person ineligible to be your health care agent.

Your health care agent shall be directed by your written instructions in this directive when making decisions on your behalf, and will be further guided by your medical condition or prognosis. Unless you state otherwise in the directive, your health care agent will have the same power to make decisions about your health care as you would have had, if those decisions made by your health care agent are made consistent with state law.

It is important that you discuss this document with your doctor or other health care providers before you sign it, to make sure you understand the nature and range of decisions

which could be made for you by your health care agent. If you do not have a health care provider, you should talk with someone who is knowledgeable about these issues and can answer your questions. Check with your community hospital or hospice for trained staff. You do not need a lawyer's assistance to complete this directive, but if there is anything in this directive you do not understand, you should ask a lawyer to explain it to you.

The person you choose as a health care agent should be someone you know and trust, and he or she must be at least 18 years old. If you choose your health or residential care provider (such as your doctor, ARNP, or an employee of a hospital, nursing home, home health agency or residential care home, other than a relative), that person will have to choose between acting as your health care agent or as your health or residential care provider, because the law does not permit a person to do both at the same time.

You should consider choosing an alternate health care agent in case your health care agent is unwilling, unable, unavailable or not eligible to act as your health care agent. Any alternate health care agent you choose will then have the same authority to make health care decisions for you, if the primary agent cannot serve.

You should tell the person you choose that you want him or her to be your health care agent. You should talk about this directive with your health care agent and your doctor or advanced registered nurse practitioner, and give each one a signed copy. You should write on the directive itself the people and institutions who will have signed copies. Your health care agent will not be liable for health care decisions made in good faith on your behalf.

Even after you have signed this directive, you have the right to make health care decisions for yourself as long as you are able to do so, and treatment cannot be given to you or stopped over your objection. However, if you have been determined by your doctor or ARNP to be incapacitated, you may want treatments to be withheld or given according to your agent's directions, even if you vocally object to those treatments.

You have the right to revoke the power given to your health care agent by telling him or her, or by telling your health care provider, orally or in writing, that you no longer want that person to be your health care agent.

Once this directive is executed it cannot be changed or modified. If you want to make changes, you must make an entirely new directive.

You have the right to exclude or strike references to advanced registered nurse practitioners in your advance directive and if you do so, your advance directive shall still be valid and enforceable.

This power of attorney for health care will not be valid unless it is signed in the presence of two (2) or more qualified witnesses, who must both be present when you sign and who will acknowledge your signature on the directive, OR in the presence of a notary public or justice of the peace. The following persons may not act as witnesses:

- The person you have designated as your health care agent
- Your spouse or heir at law, or beneficiaries named in your will or in a deed
- Your attending physician or ARNP, or person acting under the direction or control of the attending physician or ARNP

Only one of the two witnesses may be your health or residential care provider or one of your provider's employees. 🍷

NEW HAMPSHIRE ADVANCE DIRECTIVE

NOTE: This form has two sections: the Durable Power of Attorney for Health Care and the Living Will.

You may complete both sections, or only one section.

SECTION I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I, _____, (_____), hereby appoint _____
(Name) (Date of Birth) (Name of Health Care Agent)

of _____
(Health Care Agent's address and phone #)

If you choose more than one agent, they will have authority in priority of the order their names are listed, unless you indicate another form of decision making.) as my agent to make any and all health care decisions for me, except to the extent I state otherwise in this directive or as prohibited by law. This Durable Power of Attorney for Health Care shall take effect in the event I lack the capacity to make my own health care decisions.

In the event the person I appoint above is unable, unwilling or unavailable, or ineligible to act as my health care agent, I hereby appoint _____
(Name of Health Care Agent)

of _____
(Health Care Agent's address and phone #)

(Please choose only one person. If you choose more than one alternate agent, they will have authority in priority of the order their names are listed.)

Statement of Desires, Special Provisions, and Limitations about Health Care Decisions

For your convenience in expressing your wishes, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. (Life-sustaining treatment is defined as procedures without which a person would die, such as but not limited to the following: mechanical respiration, kidney dialysis or the use of other external mechanical and technological devices, drugs to maintain blood pressure, blood transfusions, and antibiotics.) There is also a section which allows you to set forth specific directions for these or other matters. If you wish, you may indicate your agreement or disagreement with any of the following statements and give your agent power to act in those specific circumstances.

A. LIFE-SUSTAINING TREATMENT

1. If I am near death and lack the capacity to make health care decisions, I authorize my agent to direct that:

(Initial beside your choice of (a) or (b).)

_____ (a) life-sustaining treatment not be started, or if started, be discontinued.

-or-

_____ (b) life-sustaining treatment continue to be given to me.

2. Whether near death or not, if I become permanently unconscious I authorize my agent to direct that:

(Initial beside your choice of (a) or (b).)

_____ (a) life-sustaining treatment not be started, or if started, be discontinued.

-or-

_____ (b) life-sustaining treatment continue to be given to me.

B. MEDICALLY ADMINISTERED NUTRITION AND HYDRATION

1. I realize that situations could arise in which the only way to allow me to die would be to not start or to discontinue medically administered nutrition and hydration. In carrying out any instructions I have given in this document, I authorize my agent to direct that:

(Initial beside your choice of (a) or (b).)

_____ (a) medically administered nutrition and hydration not be started, or if started, be discontinued.

-or-

_____ (b) even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me.

If you fail to complete item B, your agent will not have the power to direct the withholding or withdrawal of medically administered nutrition and hydration.

C. TREATMENT AGAINST OBJECTION

1. You may want your health care agent's decisions to be honored, even if you vocalize an objection to those decisions. In this context, please consider the following statement.

(Initial beside your choice of (a) or (b).)

_____ (a) Yes, even if I am incapacitated and I object to treatment, treatment **may** be given to me against my objection.

-or-

_____ (b) No, even if I am incapacitated, treatment **may not** be given to me against my objection.

D. ADDITIONAL INSTRUCTIONS

Here you may include any specific desires or limitations you deem appropriate, such as when or what life-sustaining treatment you would want used or withheld, or instructions about refusing any specific types of treatment that are inconsistent with your religious beliefs or are unacceptable to you for any other reason. You may leave this question blank if you desire.

(attach additional pages as necessary)

(Print Name)

(Date of Birth)

I hereby acknowledge that I have been provided with a disclosure statement explaining the effect of this directive. I have read and understand the information contained in the disclosure statement.

The original of this directive will be kept at _____
and the following persons and institutions will have copies:

Signed this ____ day of _____, 20__.

Principal's signature: _____

[If you are physically unable to sign, this directive may be signed by someone else writing your name, in your presence and at your express direction.]

THIS POWER OF ATTORNEY DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.

We declare that the principal appears to be of sound mind and free from duress at the time the Durable Power of Attorney for Health Care is signed and that the principal affirms that he or she is aware of the nature of the directive and is signing it freely and voluntarily.

Witness _____ Address _____

Witness _____ Address _____

If using a Notary Public or Justice of the Peace:

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing Durable Power of Attorney for Health Care was acknowledged before me this ____ day of _____, 20__, by _____ ("the Principal").

Notary Public / Justice of the Peace

My commission expires: _____

_____, _____
(Print Name) (Date of Birth)

SECTION II. LIVING WILL

Declaration made this _____ day of _____, 20__.

I, _____, being of sound mind, willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

If at any time I should have an incurable injury, disease, or illness and I am certified to be near death or in a permanently unconscious condition by two physicians or a physician and an ARNP, and two physicians or a physician and an ARNP have determined that my death is imminent whether or not life-sustaining treatment is utilized and where the application of life-sustaining treatment would serve only to artificially prolong the dying process, or that I will remain in a permanently unconscious condition, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, the natural ingestion of food or fluids by eating and drinking, or the performance of and medical procedure deemed necessary to provide me with comfort care. I realize that situations could arise in which the only way to allow me to die would be to discontinue medically administered nutrition and hydration.

In carrying out any instruction I have given under this section, I authorize that:

(Initial beside your choice of (a) or (b).)

_____ (a) medically administered nutrition and hydration not be started, or if started, be discontinued.

-or-

_____ (b) even if all other forms of life-sustaining treatment have been withdrawn, medically administered nutrition and hydration continue to be given to me.

In the absence of my ability to give directions regarding the use of such life-sustaining treatment, it is my intention that this declaration shall be honored by my family and health care providers as the final expression of my right to refuse medical or surgical treatment and accept the consequences of such refusal.

I understand the full import of this declaration, and I am emotionally and mentally competent to make this declaration.

Signed this _____ day of _____, 20__.

Principal's signature: _____

[If you are physically unable to sign, this directive may be signed by someone else writing your name, in your presence and at your express direction.]

_____, _____
(Print Name) (Date of Birth)

THIS LIVING WILL DIRECTIVE MUST BE SIGNED BY TWO WITNESSES OR A NOTARY PUBLIC OR A JUSTICE OF THE PEACE.

We declare that the principal appears to be of sound mind and free from duress at the time the Living Will is signed and that the principal affirms that he or she is aware of the nature of the directive and is signing it freely and voluntarily.

Witness _____ Address _____

Witness _____ Address _____

If using a Notary Public or Justice of the Peace:

STATE OF NEW HAMPSHIRE

COUNTY OF _____

The foregoing Living Will was acknowledged before me
this ____ day of _____, 20____, by _____ (“the Principal”).

Notary Public / Justice of the Peace

My commission expires: _____

(Print Name)

(Date of Birth)

DEFINITIONS

Attending physician or attending advanced registered nurse practitioner (ARNP) –

A doctor or ARNP who has primary responsibility for your treatment and care. An ARNP means a registered nurse having specialized clinical qualifications under state law.

Capacity to make health care decisions –

The ability to generally understand the risks and benefits of a health care decision, as well as any alternate options for treatment. This is determined by a doctor or ARNP.

CPR or Cardiopulmonary resuscitation –

Emergency medical procedure used to try to restart heartbeat and breathing, which can involve blowing into the mouth, pushing on the chest, inserting a breathing tube into the windpipe, giving medicines into your vein, and electrical shock.

Comfort care – Keeping you as comfortable and peaceful as possible, including pain medication, giving you ice chips and lip ointment, turning your body to prevent bed sores and bathing you.

DNR or Do Not Attempt Resuscitation order –

A medical order placed in your medical chart that says you do not want CPR performed if your heart or breathing stops.

Health care agent – Someone chosen as your Durable Power of Attorney for Health Care to make health care decisions when you are unable to express your own wishes for care or treatment.

Hospice care – A team approach to provide comprehensive medical, nursing and social services, spiritual care and bereavement support for you and your family near the end of life.

Intravenous or IV line – A tube placed in your vein that is used to give you fluids, blood or medication.

Life-sustaining treatment – Any medical procedure or intervention that use mechanical or medically administered means to sustain, restore, or supplant a vital function which, in the written judgment of the attending physician or ARNP would serve only to artificially postpone the moment of death, and where the person is near death or is permanently unconscious. This may include: ventilator or mechanical respiration, artificial maintenance of blood pressure, blood transfusion, kidney dialysis and other similar procedures. It does not include lessening pain through medication or the natural ingestion of food or fluids.

Medically administered nutrition (feeding) –

Using IVs or tubes to supply food when you are unable to eat. A feeding tube is a medical tube through which food or water is put into your body. It does not include the natural process of eating foods.

Medically administered hydration – Using IVs or tubes to supply water when you are unable to drink. It does not include the natural process of drinking fluids.

Near death – An incurable condition caused by injury, disease or illness that reasonable medical judgment finds will cause death at any time, so that life-sustaining treatment will only postpone death. This is determined by a doctor or ARNP working with an additional doctor.

Organ and tissue donation – Giving your usable organs for transplantation into others, which can save or improve their lives. Organs you can donate: heart, kidneys, pancreas, lungs, liver, intestines. Tissue you can donate: cornea, skin, bone marrow, heart valves, connective tissue. To be transplanted, organs must receive blood until they are removed from your body. Therefore, it may be necessary to place

you on a breathing machine temporarily or provide other organ-sustaining treatment. Doctors evaluate whether you have organs or tissue suitable for transplant at or near the time of death. Your body can still be shown and buried after your death.

Palliative care – Taking care of the whole person – body, mind and spirit. This approach views dying as natural and personal; its goal is to provide you with relief of symptoms (see Hospice care).

Permanently unconscious – A lasting condition, indefinitely without improvement, in which you are not aware of your thought, your self and environment and other indicators of consciousness are absent as determined by a neurological assessment by a doctor in consultation with your doctor or ARNP.

Persistent vegetative state – An irreversible condition where reasonable medical judgment finds the complete loss of key brain functions. It results in the end of all thinking and consciousness, although heartbeat and breathing continue. Periods of sleep and wakefulness will still occur.

Trial of treatment – To try treatment(s) for a period of time (such as 1 or 2 weeks) until it is decided that the treatment will not succeed.



FOUNDATION FOR
HEALTHY COMMUNITIES

The information contained in this booklet was prepared by the

New Hampshire Partnership for End-of-Life Care

... a group of organizations that helps people to plan for their health care,
talk about their choices and have them respected.

It has been endorsed by the following organizations:

New Hampshire Hospital Association
New Hampshire Medical Society
Home Care Association of New Hampshire
New Hampshire Health Care Association
New Hampshire Hospice and Palliative Care Organization
American Cancer Society

**Notice to
Health Care Provider**

I have:
_____ a Durable Power of Attorney
for Health Care
_____ a Living Will

The signed original document is
located at:

In case of emergency, contact:

Name

Address

City, State, Zip

Phone

Advance Directive Card

Name

Address

City, State, Zip

Signature

**Please see reverse side
for important information**

Fold Here

**Notice to
Health Care Provider**

I have:
_____ a Durable Power of Attorney
for Health Care
_____ a Living Will

The signed original document is
located at:

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