MERCY MEDICAL CENTER
Cedar Rapids, Iowa

ADVANCE DIRECTIVES FOR HEALTH CARE

I. DECLARATION RELATING TO LIFE-SUSTAINING PROCEDURES (LIVING WILL)

If I should have an incurable or irreversible condition that will result either in death within a relatively short period of time or a state of permanent unconsciousness from which, to a reasonable degree of medical certainty, there can be no recovery, it is my desire that my life not be prolonged by the administration of life sustaining procedures. If I am unable to participate in my health care decisions, I direct my attending physician to withhold or withdraw life-sustaining procedures that merely prolong the dying process and are not necessary to my comfort or freedom from pain.

II. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

I designate ____

Name of Agent   Phone #

____

Street Address   City   State   Zip Code

as my attorney-in-fact (my agent). I give to my agent the power to make health care decisions for me in the event that I am unable, in the judgement of my attending physician, to make those health care decisions. If my agent is unable to serve, I designate

____

Name of Alternate Agent   Phone #

____

Street Address   City   State   Zip Code

My agent must act consistently with my desires as stated in this document or otherwise made known. This document gives my agent the power, consistent with the laws of the State of Iowa, to consent to the withdrawal or withholding of life-sustaining procedures, as well as the power to consent to or refuse any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition. This document also gives my agent the right to examine my medical records and to consent to the disclosure of such records.

CHECK ONE BOX ONLY:

- ❑ 1. Declaration (Living Will) only.
- ❑ 2. Durable Power of Attorney for Health Care only.
- ❑ 3. Both Advance Directives.

Special Instructions Attached:

❑ Yes   ❑ No

Signed this __________day of ______________________________, ________________.

____
Signature

____
Street Address

____
Print or type name

____
City   State   Zip Code

____
Social Security Number

____
Date of Birth

STATE OF IOWA, LINN COUNTY, ss:

This document was acknowledged before me on______________________________ , __________by ______________________________.

____
Notary Public - State of Iowa

GENERAL INFORMATION REGARDING THIS DOCUMENT

1. The decision to sign a Living Will and Durable Power of Attorney for Health Care document is an important decision that should be made only after careful reflection and discussion with your loved ones and your physician.

   a. If you need assistance completing this form, contact the Mercy Medical Center Pastoral Care Department at 398-6106. A notary public is available.

   b. If you have questions about the legal effect of this document, contact your attorney.

2. Under Iowa law, "life-sustaining procedure" means any medical procedure, treatment or intervention which utilizes mechanical or artificial means to sustain, restore or supplement a vital function and when applied to a person in a terminal condition, would only serve to prolong the dying process.

   a. "Life-sustaining procedure," includes nutrition and hydration (food and water) only when provided parenterally (intravenously) or through intubation (by feeding tube). Thus, this document authorizes the withholding of nutrition and hydration that is provided intravenously or by feeding tube. If this is not what you want, you should set forth your specific instructions and attach to this document.

   b. "Life-sustaining procedure" does not include administration of medication or performance of any medical procedure deemed necessary to provide comfort care or alleviate pain.

3. You may <u>not</u> designate the following individuals as your agent to make health care decisions for you under your Durable Power of Attorney for Health Care:

   a. A health care provider attending you on the date you sign this document.

   b. An employee of such a health care provider unless the individual to be designated is related to you by blood, marriage or adoption within the third degree of consanguinity.

4. You may revoke your Living Will or Durable Power of Attorney for Health Care at any time in any manner by which you are able to communicate your intent to revoke, without regard to your mental or physical condition.

5. It is your responsibility to provide your hospital and attending physician with this document. You should also provide a copy for your family members, your designated agent and your alternate designated agents, if any. Place the original in a safe place that is known and accessible to family members or close friends.

6. A copy of this document shall have the same force and effect as the original.