Advance Directive - MONTANA

Providence St. Joseph Health

Step 1: Choose your health care representative.

Name someone you trust to make health care choices for you if you are unable to make your own decisions. Think about the people in your life – your family and friends. Select someone to be your health care representative. Ask that person if he or she is willing to do this for you.

Choose a family member or friend who:

- Is 18 or older and knows you well
- Is willing to do this for you
- Is able to make difficult decisions based on your wishes
- Will effectively communicate the information you provide in this packet to health care providers and family members

Your health care representative can:

- Decide where you will receive care
- Select or dismiss health care providers
- Say yes/no to medications, tests, treatments
- Say what happens to your body and organs after you die
- Take legal action needed to carry out your wishes

Your representative **cannot** be your doctor or someone who works at the hospital or clinic where you are receiving care unless he or she is a member of your family.

Name your health care representative.

1) I want this person to make my medical decisions if I cannot make my own:

First name	Last name		Relationship	
Home/Cell phone	Work phone		Email	
Street address		City	State	ZIP code

If the first person cannot make my medical decisions, then I want this other person:

First name	Last name		Relationship	
Home/Cell phone	Work phone		Email	
Street address		City	State	ZIP code

2) Put an X next to the sentence you agree with:

___ My health care representative will make decisions for me **only** after I become unable to make my own decisions.

OR

___ My health care representative can make decisions for me **right now** after I sign this form.

This advance directive belongs to: (please print your name on this line) **Date of Birth**

Step 2: Make your health care choices.

What makes your life worth living?

1) My life is (choose A or B):

___ A) Always worth living no matter how sick I am

___ B) Only worth living if (check all that are true for you):

- ___ I can talk with family and friends
- ___ I can wake up from a coma
- ___ I can feed, bathe or take care of myself
- ___ I can be free from pain
- ___ I can live without being hooked up to machines
- ___ I am not sure

2) If I am dying, it is important for me to be (choose one):

___ At home

___ In a hospital or other care center

___ It is not important to me where I am cared for

Religion or spiritual beliefs

1) Is religion or spirituality important to you?

___ Yes ___ No

2) Do you have a religion or faith tradition? If so, what is it?

_____

3) What should your doctors know about your religious or spiritual beliefs?

_____

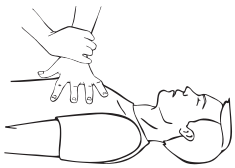
_____

_____

This advance directive belongs to: (please print your name on this line) **Date of Birth**

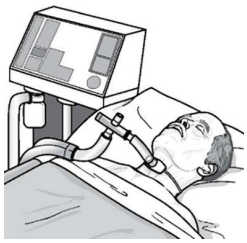
Step 2: Make your health care choices, continued.

Life support



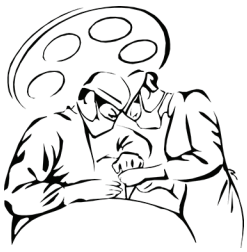
Life-support procedures may be used to try to keep you alive. They include:

CPR or cardiopulmonary resuscitation — This may involve:
- Pressing hard on your chest to keep your blood pumping
- Electrical shocks to jump-start your heart
- Medicines in your veins



Breathing machine or ventilator — This machine pumps air into your lungs and breathes for you through a tube placed in your throat. You are not able to talk or eat when you are on the machine.

Dialysis — This machine cleans your blood if your kidneys stop working.



Feeding tube — This tube provides food to your body if you cannot swallow. The tube is placed down your throat into your stomach. It can also be placed surgically.

Blood transfusion — This will put blood in your veins.

Surgery and/or medicines

Put an X next to the one statement you most agree with.

If I am so sick that I may die soon:

___ Try all life-support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, **I want to stay on life-support machines** even if I am suffering.

___ Try all life-support treatments that my doctors think might help. If the treatments do not work and there is little hope of getting better, **I do NOT want to stay on life-support machines.** If I am suffering, I want life-support treatments to stop so that I can be allowed to die gently.

___ **I do NOT want life-support treatments.** I want to focus on my comfort. I prefer to have a natural death.

___ I want my **health care representative** to decide.

___ I am not sure what I would like done.

This advance directive belongs to: (please print your name on this line) **Date of Birth**

Step 2: Make your health care choices, continued.

Donating your organs

Your doctors may ask about organ donation and an autopsy after you die. Donating your organs can help save lives. Put an **X** next to the **one** choice you most agree with.

___ I **want** to donate my organs:

- ___ Any organ, all that might be usable.
- ___ Only certain organs (please specify which organs or tissues you wish to donate).

_____

_____

___ I **do not** want to donate any of my organs.

___ I want my **health care representative** to decide.

___ I am not sure what I would like done.

Autopsy

An autopsy can be done after death to find out why someone died. It's a surgical procedure. It can take a few days. In some cases an autopsy may be required by law. Put an **X** next to the **one** choice you most agree with.

___ I **want** an autopsy.

___ I **do not** want an autopsy.

___ I want an autopsy **only if there are questions** about the cause(s) of my death.

___ I want my **health care representative** to decide.

___ I am not sure what I would like done.

Step 2: Make your health care choices, continued.

Other things to consider

What other wishes are important to you after you die? For example, are there any cultural, religious, or spiritual things about how to treat your body that your health care team should know?

Do you have someone who should be contacted for funeral or burial wishes? If yes, who?

Step 3: Outline your health care representative's authority.

Your health care representative can help make the following decisions about:

Life-support treatments - medical care to help you live longer:

- CPR or cardiopulmonary resuscitation
- Breathing machine or ventilator
- Dialysis
- Feeding Tube
- Blood Transfusion
- Surgery
- Medicines

End-of-life care

If you might die soon, your health care representative can:

- Call a spiritual leader
- Decide if you die at home or in the hospital
- Decide whether an autopsy will be performed
- Decide whether your organs may be donated
- Decide where you should be buried or cremated

How do you want your health care representative to follow your medical wishes?

Put an **X** next to the one sentence you most agree with:

___ **Total flexibility:** It is OK for my health care representative to change **any** of my medical decisions if, after talking with my doctors, he/she thinks it is best for me at that time.

___ **Some flexibility:** It is OK for my health care representative to change **some** of my medical decisions if, after talking with my doctors, he/she thinks it is best for me at that time.

___ **Minimal flexibility:** I want my health care representative to follow my medical wishes as closely as possible. Please respect my decisions even if doctors recommend otherwise.

Use additional pages, if necessary, to answer the questions below.

These are some of my wishes I really want respected:

Write down any decisions you **do not** want your health care representative to make:

This advance directive belongs to: (please print your name on this line) **Date of Birth**

Providence St. Joseph Health

Step 4: Sign the form—your signature.

Before this form can be used, you must:

- Sign this form if you are at least 18
- Have two witnesses sign the form

Sign your name and write the date.

Signature Date

Print name

Street address City State ZIP code

Witnesses

Before this form can be used, you must have two witnesses sign the form.

Your witnesses should:

- Be at least 18
- Acknowledge that you signed this form

Your witnesses cannot:

- Be the person you named as your health care representative

Providence St. Joseph Health **recommends** that your witnesses not:

- Be your doctor or other health care provider

This advance directive belongs to: (please print your name on this line) **Date of Birth**

Step 4: Sign the form, continued.

Witnesses' signatures

Have your witnesses complete this page.

By signing, I promise that _____ acknowledged that he/she signed this form.
Name of advance directive owner

I believe he/she was thinking clearly and was not forced to sign this form.

I also promise that:

- This person could prove who he/she was
- I am at least 18
- I am not his/her health care representative

Witness #1

Signature Date

Print name

Street address City State ZIP code

Witness #2

Signature Date

Print name

Street address City State ZIP code

This advance directive belongs to: (please print your name on this line) **Date of Birth**

Step 5: Submit a copy of your completed advance directive.

Once you have signed your advance directive and it has been witnessed and/or notarized, keep the original and make copies of pages 1-8 to send to your:

- Health care representative
- Family
- Friends
- Medical providers
- Hospital

Options for returning your completed advance directive:

Return a **COPY** to your preferred Providence St. Patrick Hospital, Providence St. Joseph Medical Center (Polson), or Providence Medical Group provider at your next visit.

If you have any questions related to completing or returning your advance directive, please contact:

The Learning Center
500 W. Broadway, Level 1, Broadway Building
Missoula, MT 59802
406-329-5710

For more information, visit us at:
Providence.org/InstituteForHumanCaring

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With special thanks to:

- Rebecca Sudore, M.D., Division of Geriatrics, University of California, San Francisco
- Cedars-Sinai, Los Angeles, CA

Montana Department of Justice
Office of Consumer Protection

MONTANA
END-OF-LIFE REGISTRY
https://dojmt.gov/consumer/end-of-life-registry/

Consumer Registration Agreement

For office use only

PO Box 201410, Helena, MT 59620-1410 • Phone (406) 444-0660 or (866) 675-3314 • E-mail: endofliferegistry@mt.gov

This form indicates your desire to store an advance directive in the Montana End-of-Life Registry, to replace or remove an Advance Directive already in the Registry, or to request a replacement wallet card.

- Read this Agreement carefully and fill in Sections A through C completely.
- Attach your witnessed Advance Directive.
- Return this Agreement with your Advance Directive to the Office of Consumer Protection at the address above.
- Your Consumer Registration Agreement will be processed within three weeks. You will receive further information in the mail.

Section A

Prefix	First Name	Middle Name or Initial	Last Name	Suffix

Gender	Date of Birth (Month/Day/Year)	Mother's Maiden Name	Social Security Number	Phone Number

Mailing Address				
City	**State**	**Zip**	**County**	**Country**

Section B

Pick a level of privacy:

- ☐ **Standard Privacy:** If the information on my wallet card is unavailable, in addition to health care providers, people who enter my Social Security Number, date of birth and mother's maiden name can view my advance directive.
- ☐ **Higher Privacy:** Only people who have the information from my wallet card and health care providers can view my advance directive.

I want to:

- ☐ **Store an advance directive in the Registry.**
- ☐ **Replace an advance directive in the Registry with a new one.**
- ☐ **Add an Addendum to my current directive**
- ☐ **Remove my advance directive from the Registry.**
- ☐ **Request a replacement wallet card.**

Section C

I am providing this personal information along with my advance directive, with the understanding that my personal information will be stored in a secure Department of Justice database and will not be available to the public. I certify that the advance directive that accompanies this Agreement is my current effective advance directive and was duly executed, witnessed and acknowledged in accordance with Section 50-9-103 of the Montana Code Annotated.

I understand that:

- my advance directive will be entered in the Montana End-of-Life Registry free of charge;
- this authorization is voluntary;
- this authorization to store my advance directive in the Montana End-of-Life Registry will remain in force until I revoke it;
- I may revoke this authorization at any time by giving written notice of my revocation to the address listed above; and

no agency, provider or individual may be held liable for any action based on this authorization before a written notice of revocation has been entered into the Registry.

_____ _____

Signature of Person Signing This Agreement Date

If the person named in the advance directive is unable to sign this form, and you have legal authority to sign for that person, please check the source of your authority and provide proof thereof. ☐ Durable Power of Attorney ☐ Court Appointed Guardian