STATE OF RHODE ISLAND ADVANCE DIRECTIVES INSTRUCTIONS

To Living Will

A living will is a written document which directs your physician to withhold or stop life-sustaining medical procedures if you develop a terminal condition and can't state your wishes at the time a decision about those kinds of procedures must be made.

Rhode Island law suggests a form of living will but does not require its exclusive use. If you decide to sign a living will, you may use the form supplied with these instructions or make your own living will form. If you use this form, please read and follow these instructions carefully.

1. Print your name in the first line of the form.

2. Place a check mark in the third paragraph to indicate whether you want artificially administered nutrition and hydration (food and water) to be stopped or withheld like any other life-sustaining treatment. Remember, if you do not want artificial nutrition and hydration, your living will must say so.

3. Complete the day, month and year that you sign at the bottom of this form.

4. Sign your name on the signature line (or if you are unable to do so, have someone do it for you) before two (2) witnesses who know you and are at least 18 years old.

5. Print your address on the address line.

6. Have the two (2) witnesses sign their names and print their addresses where indicated below your signature. The witnesses may not be related to you by blood or marriage.

7. Give a signed copy of your living will to your physician for your medical records.

Remember, you may revoke your living will at any time simply by telling your physician not to follow it.

NOTE: This information is provided to make you generally aware of Rhode Island law about living wills and is not intended as legal advice for your particular situation. For legal advice about living wills or your health care rights, you should consult with an attorney.

STATE OF RHODE ISLAND
CHAPTER 23-4.11
A declaration may, but need not, be in the following form:
RIGHTS OF THE TERMINALLY ILL ACT

DECLARATION

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 I should have an incurable or irreversible condition that will cause my death and if I am unable to make decisions regarding my medical treatment, I direct my attending physician to withhold or withdraw procedures that merely prolong the dying process and are not necessary to my comfort, or to alleviate pain.

This authorization ☐ includes

☐ does not include

the withholding or withdrawal of artificial feeding **(check only one box above).**

Signed this _____day of _____, 20___.

_____
(Signature of Declarant)

_____ _____
(address) (print your name)

_____ _____
(city) (state) (zip code) (your social security number)

The declarant is personally known to me and voluntarily signed this document in my presence.

SIGNATURES OF WITNESSES:

First witness	Second witness
_____	_____
(signature of witness)	(signature of witness)
_____	_____
(print name)	(print name)
_____	_____
(address)	(address)
_____	_____
(city) (state) (zip code)	(city) (state) (zip code)
_____	_____
(date)	(date)

DISCLAIMER: The law allows you to complete advance directives without the assistance of legal counsel. America Living Will Registry provides these advance directive forms as a service to you and does not take responsibility for the manner in which you complete them. If you have any questions about any part of these advance directive forms, be sure to consult an attorney before you sign them.

INTRODUCTION

YOUR RIGHTS

Adults have the fundamental right to control the decisions relating to their health care. You have the right to make medical and other health care decisions for yourself so long as you can give informed consent for those decisions. No treatment may be given to you over your objection at the time of treatment. You may decide whether you want life sustaining procedures withheld or withdrawn in instances of a terminal condition.

What is a Durable Power of Attorney for Health Care?

This Durable Power of Attorney for Health Care lets you appoint someone to make health care decisions for you when you cannot actively participate in health care decision making. The person you appoint to make health care decisions for you when you cannot actively participate in health care decision making is called your agent. The agent must act consistent with your desires as stated in this document or otherwise known. Your agent must act in your best interest. Your agent stands in your place and can make any health care decision that you have the right to make.

You should read this Durable Power of Attorney for Health Care carefully. Follow the witnessing section as required. To have your wishes honored, this Durable Power of Attorney for Health Care must be valid.

REMEMBER

- You must be at least eighteen (18) years old.
- You must be a Rhode Island resident.
- You should follow the instructions on this Durable Power of Attorney for Health Care.
- You must voluntarily sign this Durable Power of Attorney for Health Care.
- You must have this Durable Power of Attorney for Health Care witnessed properly.
- No special form must be used but if you use this form it will be recognized by health care providers.
- Make copies of your Durable Power of Attorney for Health Care for your agent, alternative agent, physicians, hospital, and family.
- Do not put your Durable Power of Attorney for Health Care in a safe deposit box.
- Although you are not required to update your Durable Power of Attorney for Health Care, you may want to review it periodically.

DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(RHODE ISLAND HEALTH CARE ADVANCE DIRECTIVE)

I, _____,
(Insert your name and address)
am at least eighteen (18) years old, a resident of the State of Rhode Island, and understand this document allows me to name another person (called the health care agent) to make health care decisions for me if I can no longer make decisions for myself and I cannot inform my health care providers and agent about my wishes for medical treatment.

PART I: APPOINTMENT OF HEALTH CARE AGENT
THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS FOR ME IF I CAN NO LONGER MAKE DECISIONS

Note: You may not appoint the following individuals as an agent:

(1) your treating health care provider, such as a doctor, nurse, hospital, or nursing home,
(2) a nonrelative employee of your treating health care provider,
(3) an operator of a community care facility, or
(4) a nonrelative employee of an operator of a community care facility.

When I am no longer able to make decisions for myself, I name and appoint _____ _____to make health care decisions for me. This person is called my health care agent.

Telephone numbers of my health care agent: _____

Address of my health care agent: _____

You should discuss this health care directive with your agent and give your agent a copy.

(OPTIONAL)
APPOINTMENT OF ALTERNATE HEALTH CARE AGENTS:

You are not required to name alternative health care agents. An alternative health care agent will be able to make the same health care decisions as the health care agent named above, if the health care agent is unable or ineligible to make health care decisions for you. For example, if you name your spouse as your health care agent and your marriage is dissolved, then your former spouse is ineligible to be your health care agent.

When I am no longer able to make decisions for myself and my health care agent is not available, not able, loses the mental capacity to make health care decisions for me, becomes ineligible to act as my agent, is not willing to make health care decisions for me, or I revoke the person appointed as my agent

to make health care decisions for me, I name and appoint the following persons as my agent to make health care decision for me as authorized by this document, in the order listed below:

My **First Alternative Health Care Agent**: _____

Telephone number of my first alternative health care agent: _____

Address of my first alternative health care agent: _____

_____

My **Second Alternative Health Care Agent**: _____

Telephone number of my second alternative health care agent: _____

Address of my second alternative health care agent: _____

_____

My health care agent is automatically given the powers I would have to make health care decisions for me if I were able to make such decisions. Some typical powers for a health care agent are listed below in (A) through (H). My health care agent must convey my wishes for medical treatment contained in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest. A court can take away the power of an agent to make health care decisions for you if your agent:

(1) Authorizes anything illegal,

(2) Acts contrary to your known wishes, or

(3) Where your desires are not known, does anything that is clearly contrary to your best interest.

Whenever I can no longer make decisions about my medical treatment, my health care agent has the power to:

(A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatments, services, tests, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about mental health treatment.

(B) Advocate for pain management for me.

(C) Choose my health care providers, including hospitals, physicians, and hospice.

(D) Choose where I live and receive health care which may include residential care, assisted living, a nursing home, a hospice, and a hospital.

(E) Review my medical records and disclose my health care information, as needed.

(F) Sign releases or other documents concerning my medical treatment.

(G) Sign waivers or releases from liability for hospitals or physicians.

(H) Make decisions concerning participation in research.

If I DO NOT want my health care agent to have a power listed above in (A) through (H) OR if I want to LIMIT an power in (A) through (H), I must say that here: _____

_____

_____

PART II: HEALTH CARE INSTRUCTIONS

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

Many medical treatments may be used to try to improve my medical condition in certain circumstances or to prolong my life in other circumstances. Many medical treatments can be started and then stopped if they do not help. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start the heart, surgeries, dialysis, antibiotics, and blood transfusions. The back inside page has more information about life-support measures.

OPTIONAL -FOR DISCUSSION PURPOSES

A discussion of these questions with your health care agent may help him or her make health care decisions for you which reflect your values when you cannot make those decisions.

These are my views which may help my agent make health care decisions:

1. Do you think your life should be preserved for as long as possible? Why or why not?

2. Would you want your pain managed, even if it makes you less alert or shortens your life?

3. Do your religious beliefs affect the way you feel about death? Would you prefer to be buried or cremated?

4. Should financial considerations be important when making a decision about medical care?

5. Have you talked with your agent, alternative agent, family and friends about these issues?

Here are my desires about my health care to guide my agent and health care providers.

1. If I am close to death and life support would only prolong my dying:

INITIAL ONLY ONE:
_____I want to receive a feeding tube.
_____I DO NOT WANT a feeding tube.

INITIAL ONLY ONE:
_____I want all life support that may apply.
_____I want NO life support.

2. If I am unconscious and it is very unlikely that I will ever become conscious again:

INITIAL ONLY ONE:
_____I want to receive a feeding tube.
_____I DO NOT WANT a feeding tube.

INITIAL ONLY ONE:
_____I want all life support that may apply.
_____I want NO life support.

3. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

INITIAL ONLY ONE:
_____I want to receive a feeding tube.
_____I DO NOT WANT a feeding tube.

INITIAL ONLY ONE:
_____I want all life support that may apply.
_____I want NO life support.

Additional statement of desires, special provisions, and limitations regarding health care decisions _____

_____

ORGAN DONATION

_____ In the event of my death, I request that my agent inform my family or next of kin of my desire to be an organ and tissue donor for **transplant**. *(Initial if applicable)*

_____ In the event of my death, I request that my agent inform my family or next of kin of my desire to be an organ and tissue donor for **research**. *(Initial if applicable)*

RELIGIOUS AND SPIRITUAL REQUESTS

Do you want your Rabbi, Priest, Clergy, Minister, Imam, Monk, or other spiritual advisor contacted if you become sick?

INITIAL ONLY ONE:

_____ Yes _____No

Name of Rabbi, Priest, Clergy, Minister, Imam, Monk, or other spiritual advisor:

_____

Address:_____

Phone Number: _____

DURATION

Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.

I do not want this durable power of attorney for health care to exist until revoked. I want this durable power of attorney for health care to expire on _____

(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)

REVOCATION

I can revoke this Durable Power of Attorney for Health Care at any time and for any reason either in writing or orally. If I change my agent or alternative agents or make any other changes, I need to complete a new Durable Power of Attorney for Health Care with those changes.

PART III: MAKING THE DOCUMENT LEGAL

I revoke any prior designations, advance directives, or durable power of attorney for health care.

Date and Signature of Principal

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

Signature _____ Date signed:_____

DATE AND SIGNATURES OF TWO QUALIFIED WITNESSES OR ONE NOTARY PUBLIC

Two qualified witnesses or one notary public must sign the durable power of attorney for health care form at the same time the principal signs the document. The witnesses must be adults and must not be any of the following:

(1) a person you designate as your agent or alternate agent,
(2) a health care provider,
(3) an employee of a health care provider,
(4) the operator of a community care facility, or
(5) an employee of an operator of a community care facility.

I declare under the penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, or an employee of an operator of a community care facility.

OPTION ONE:

Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

Signature: _____

Print Name: _____

Residence Address: _____

Date: _____

----------OR----------

OPTION TWO:

Signature of Notary Public: _____

Print Name: _____

Commission Expires: _____

Business Address: _____

Date: _____

TWO QUALIFIED WITNESSES OR ONE NOTARY PUBLIC DECLARATION

At least one of the qualified witnesses or the notary public must make this additional declaration:

I further declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

Print Name: _____

Signature: _____

Print Name: _____

PART IV: DISTRIBUTING THE DOCUMENT

You are not required to give anyone your Durable Power of Attorney for Health Care, but if it cannot be found at the time you need it, it cannot help you. For example, you are unable to participate in making health care decisions and your Durable Power of Attorney for Health Care is a safe deposit box, the agent, physician and other health care providers will not have access to it and they will not be able to respect your medical treatment wishes. You may want to give a copy of your Durable Power of Attorney for Health Care to some or all of the persons listed below so that it can be available when you need it.

(Name) (Address) (Phone)

- ❑ Health Care Agent_____
- ❑ First Alternative Health Care Agent_____
- ❑ Second Alternative Health Care Agent_____
- ❑ Physician_____
- ❑ Family_____
- ❑ Lawyer_____
- ❑ Others_____

ADDITIONAL SPACE FOR INFORMATION

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COMMONLY USED LIFE-SUPPORT MEASURES

Cardiopulmonary Resuscitation (CPR)

Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

When used quickly in response to a sudden event like a heart attack or drowning, CPR can be life-saving. But the success rate is extremely low for people who are at the end of a terminal disease process. Critically ill patients who receive CPR have a small chance of recovering or leaving the hospital.

Rhode Islanders with a terminal condition who do not want rescue/ambulance service/emergency medical services personnel to perform CPR may join COMFORT ONE. Rescue/ambulance/emergency workers will provide comfort measures but will not perform CPR or any resuscitation. To join COMFORT ONE, speak to your physician. ONLY your physician can enroll you in the COMFORT ONE PROGRAM. Your physician writes a medical order directing rescue/ambulances service/emergency personnel not to start CPR which is filed with the Rhode Island Department of Health.

Mechanical Ventilation

Mechanical ventilation is used to help or replace how the lungs work. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea). Mechanical ventilation often is used to assist a person through a short-term problem or for prolonged periods in which irreversible respiratory failure happens due to injuries to the upper spinal cord or a progressive neurological disease.

Some people on long-term mechanical ventilation are able to enjoy themselves and live a quality of life that is important to them. For the dying patient, however, mechanical ventilation often merely prolongs the dying process until some other body system fails. It may supply oxygen, but it cannot improve the underlying condition.

When discussing end-of-life wishes, make clear to loved ones and your physician whether you would want mechanical ventilation if you would never regain the ability to breathe on your own or return to a quality of life acceptable to you.

Artificial Nutrition and Hydration

Artificial nutrition and hydration (or tube feeding) supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluid through a tube placed directly into the stomach, the upper intestine, or a vein. Artificial nutrition and hydration can save lives when used until the body heals.

Long-term artificial nutrition and hydration may be given to people with serious intestinal disorders that impair their ability to digest food, thereby helping them to enjoy a quality of life that is important to them. Sometimes long-term use of tube feeding frequently is given to people with irreversible and end-stage conditions which will not reverse the course of the disease itself or improve the quality of life. Some health care facilities and physicians may not agree with stopping or withdrawing tube feeding. You may want to talk with your loved ones and physician about your wishes for artificial nutrition and hydration in your Durable Power of Attorney for Health Care.