

Facts about Health Care Advance Directives

A health care advance directive can give you and your family peace of mind.

Under Maine law, the term “advance directive” means any spoken or written instructions you give about the health care you want if a time comes when you are too ill to decide. It is best to write it all down because some instructions are required to be in writing. A health care power of attorney is an example of an advance directive that must be in writing.

If you have already signed an advance directive, put it in a safe place and be sure your physician, hospital, and family have a copy. A copy of the signed form is as good as the signed original. If you have not signed a form yet, you may choose to use the Maine Health Care Advance Directive Form. If you become too ill to make choices about your care, the form will let others know which treatments you want and which you do not. This spares family members from having to guess.

The 7 parts of the Maine Health Care Advance Directive Form allow many choices.

Anyone 18 or older may use the Maine Health Care Advance Directive Form in whole or in part. If you are younger than 18, you may also be able to use an advance directive under certain limited circumstances.

Each part is about a different choice. You must sign your advance directive in Part 6. You can get help filling it out and you can take your time. Here’s what each part is about.

Part 1. Choose an agent. This part is called a Health Care Power of Attorney where you name a person to make health care decisions for you. The person you choose to make your health care decisions is your agent. Your agent can be an adult family member or friend. A person who owns or works at the nursing home or other residential facility where you live cannot be your agent, unless the person is also a member of your family.

If you choose an agent, two adult witnesses must sign your advance directive. Your agent may not be a witness.

Part 2. Choose treatments you want and don’t want. In this part you can choose what you wish to have done or not done if you are dying, in a coma or too ill to speak for yourself. Your agent must follow any choices you make in an advance directive.

Part 3. Name your primary care physician (or nurse practitioner or physician assistant).

Part 4. State your wishes about donating your body, organs or tissues at death.

Part 5. State your wishes about funeral and burial arrangements.

Part 6. Sign and date your advance directive.

Part 7. Sign a Do Not Resuscitate (DNR) form. If your breathing or your heart stops and you do not want an ambulance crew to try to revive you, this form must be signed by you and by your physician (or nurse practitioner or physician assistant).





Your physician generally must follow the choices in your advance directive.

You can choose the time when your health care advance directive takes effect:

1. **Right away.** This means that your agent can start making health care decisions for you right away. In this case, you will be told about your agent's decisions. As long as you are able to make your own decisions, you may override your agent's decision if you wish.

OR

2. **Only if you are too sick to make decisions yourself.** In this case, your physician will decide when the form goes into effect.

In either case, health care providers and facilities must follow your choices, except in very rare situations. For example, health care providers are not required to give treatment that is not medically effective or treatment that is against accepted standards of care. If your health care provider or facility cannot follow your choices, they must tell you the reason why. They also must assist in moving you to a health care provider or facility that will carry out your decisions.

If you get too sick to make decisions and you don't have an agent, a health care advance directive or a guardian named by a court, Maine law directs your physician to ask certain family members to make decisions for you.

If you do not have an agent, an advance directive or a guardian appointed by a judge, your physician will ask family members what treatment you would want, in this order:

- Spouse (unless legally separated);
- Someone with whom you share an emotional, physical and financial bond similar to a spouse;
- Your adult children;
- Your parents;
- Your adult brothers and sisters;
- Your adult grandchildren;
- Your adult nieces and nephews; and
- Your adult aunts and uncles.

If your physician cannot reach one of these family members, she/he may ask another adult relative or good friend who knows your values. If there are family members or others whom you do not want making decisions for you, make sure you put this in writing and tell your physician.


If you do *not* have an advance directive, family members may tell your physician how to treat you. If you are not close to death or in a permanent coma, they may not refuse treatment that your physician thinks is lifesaving and medically necessary. They may also make some other decisions for you. If you are close to death or you are in a permanent coma, they can tell your physician not to give treatment to keep you alive (life-sustaining treatment).

You always have certain rights as a patient.

When you need medical care, you have certain rights, including the right to refuse care. A health care advance directive does not take away your rights as a patient.

You always have a right to know:



- 
- What your medical problem is and what tests and treatments may be needed;
 - What your physician thinks can be done and what the usual risks may be;
 - If there are other ways to care for you; and
 - What may happen if you refuse treatment.


If you are too ill to make decisions for yourself, the person making decisions for you also has a right to know this information.

If your breathing or your heart stops and you do not want an ambulance crew to try to start them again, you and your physician (or nurse practitioner or physician assistant) must sign a Do Not Resuscitate (DNR) form and make sure medical personnel know about it.

Part 7 of the Maine Health Care Advance Directive Form includes a Do Not Resuscitate (DNR) form. If you choose to complete this section, it lets your physician and ambulance crews know that you do not want drugs, machines or CPR to be used to restart your breathing or heart beat. You and your physician (**or** nurse practitioner **or** physician assistant) must both sign the DNR form. Make sure your family and other caregivers have copies of your signed DNR form. It's wise to carry it with you or wear health alert jewelry that tells others that you do not want to be revived if your breathing or heart stops.

If your breathing or heart stops at home and you don't want an ambulance crew to try to revive you, you must make sure that those who live with you know this so that they can immediately show the ambulance crew your signed DNR form or your health alert

jewelry. Keep your signed DNR form in the most visible area near you.



If your breathing or your heart stops while you are receiving home health or hospice services and you do not want staff to try to start them again, your physician must write a DNR order in your plan of care.

The physician in charge of your home health or hospice services must include a DNR order in your plan of care, even if you signed a DNR form as part of your advance directive form.


If your breathing or your heart stops while you are in the hospital or nursing home and you do not want staff to try to start them again, your physician must write a DNR order in your medical record.

Federal law requires health care facilities to have a physician's DNR order written in your medical record, even if you signed a DNR form as part of your advance directive form before you were admitted to the hospital or nursing home.

A health care advance directive does not apply to your money or property.

Your health care agent can not make decisions about your money or your property. You need to appoint a financial power of attorney to make these decisions for you, using a different form. Discuss this with your lawyer.

If you have a mental health condition, there is another form you may choose to use.



If you have a mental health condition and you wish to make choices in advance about the care you want, you may also use a mental health directive form. Contact the Maine Disability Rights Center to get a sample form at 1-800-452-1948 or print it from this web site: <http://www.drcme.org/publications.asp?pubid=16>. The Maine Disability Rights Center staff can also help you fill out the form.





You have the right to request health care advance directive forms, sign or not sign a form, and change your mind.

No one can make you sign a health care advance directive or stop you from signing one. You also have the right to change or cancel a form at any time or change your agent. An advance directive form does not allow anyone to violate laws against mercy killing and euthanasia.

Every hospital, nursing home and many other places that provide health care in Maine have these forms or can tell you how to get them. Ask your physician (**or** nurse practitioner **or** physician assistant). They can explain the forms but cannot give you legal advice.

The Maine law about advance directives is called the Uniform Health Care Decisions Act. It is available on this web site:

<http://janus.state.me.us/legis/statutes/18-a/title18-Ach5sec0.html>.

You, or those people making your decisions for you, have the right to file a complaint if your health care advance directive was not handled correctly.

If you have a complaint about how a hospital or other health care facility handled your health care advance directive, you may contact:

Division of Licensing and Regulatory Services
Maine Department of Health and Human Services
State House Station 11, 41 Anthony Ave.
Augusta, ME 04333
Tel: 207-287-9300 or 1-800-383-2441



If you have a complaint about how a physician or physician assistant handled your health care advance directive, you may contact:

Maine Board of Licensure in Medicine
137 State House Station
Augusta, ME 04333-0137
Tel: 207-287-3601 OR Complaints: 1-888-365-9964

OR

State of Maine Board of Osteopathic Licensure
142 State House Station
Augusta, ME 04333-0142
Tel: 207-287-2480 OR Complaints: 1-888-365-9964

If you have a complaint about how a nurse practitioner handled your health care advance directive, you may contact:

Maine State Board of Nursing
158 State House Station
Augusta, ME 04333-0158
Tel: 207-287-1133





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Maine Health Care Advance Directive Form

You may use this form now to tell your physician and others what medical care you want to receive if you become too sick in the future to tell them what you want. **You may choose to fill out the whole form or any part of the form and then sign and date the form in Part 6.** These are the parts:

Part 1	Fill this out if you want to choose someone to make all your health care decisions for you, either right away or if you become too sick to tell others what you want. This person is called your agent.
Part 2	Fill this out if: (1) you did not name an agent in Part 1 and now want to choose whether you want certain treatments or , (2) you did name an agent in Part 1 and want to tell your agent your wishes about certain treatments, knowing that your agent must follow your directions.
Part 3	Fill this out if you want to give the name of your primary physician, physician assistant or nurse practitioner.
Part 4	Fill this out if you want to make decisions about donating your organs, body or tissues after your death.
Part 5	Fill this out if you want: (1) to choose someone to make all funeral and burial decisions after your death, or (2) to tell your family any wishes you have about funeral and burial decisions.
Part 6	You must sign and date your Advance Directive form on this page. Have two witnesses sign the form at the same time you sign it. Tell others about your decisions and give copies to your physician, other health care providers, family and hospital.
Part 7	If you do not wish to be revived by ambulance crews should your heart or breathing stop, then you and your physician (or nurse practitioner or physician assistant) need to sign this Do Not Resuscitate (DNR) form.





Note

You may change any part of this form except for Part 6 and Part 7. You may cross out any words, sentences, or paragraphs you do not want. You can also add your own words. If you make any changes to the form, it is best if you put your initials and the date next to each change so that everyone knows it was your decision to make the change. The form lets you choose different ways to handle your care by checking boxes or filling in blanks. You may initial each box and each blank you fill in to show that it was your decision to check the box or fill in the blank.

Before filling out this form, we suggest that you talk with your lawyer, family members, physicians, and others close to you about your wishes. If you make changes or complete a new form, be sure to let everyone know.

My Name *(please print)* _____

My Address _____

My Birth date _____



This is a list of all the people who have copies of my signed health care advance directive:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____






Part 1 – Power of Attorney for Health Care

Instructions:

This part lets you choose another person to make health care decisions for you, either right away or when you are too sick to choose your own care. The person you choose is called your agent. You may also name a second and third choice to be your agent, if your first choice is not willing, reasonably available or able to make decisions for you. If you choose an agent on this form, but do not fill out any other parts of the form, your agent will be able to:

- Make all health care decisions for you, including decisions regarding tests, surgery and medication;
 - Decide whether or not to have food or fluids given to you through tubes or fed into your veins through an IV;
 - Decide whether or not to use treatments or machines to keep you alive or to restart your heart or breathing;
 - Choose who will give you health care and where you will get it, such as hospitals, nursing homes, assisted living settings, home health, or hospice care; and
 - Make any health decision he or she believes would be consistent with your values or in your best interest, even if it is not listed in the form.
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Who can be your agent:

You can name any adult you trust to be your agent, except your agent may not be the owner, operator or employee of a nursing home or residential long-term care facility where you are receiving care, unless that person is your relative.

How your agent must make decisions:

If your agent does not know what you want, the agent must make decisions consistent with your personal values, if known, or based on your best interests. In Part 2, you can decide what you want in advance. If you make choices in Part 2, your agent must make decisions based on those choices.

Who can see your health care information:

Once your agent has the right to make health care decisions for you, your agent can look at your medical records and consent to giving your medical information to others. The state and federal privacy laws let your agent see all of your health information so that he or she can make the right decision for you.

The first part of your advance directive begins on the next page.





YOUR ADVANCE DIRECTIVE BEGINS HERE

Choosing an agent: Fill in your name and the name of the person you choose to be your agent to make health care decisions for you here:

My name _____

My agent's name _____

Title or relationship to me _____

My agent's address _____

My agent's home phone (____) _____ My agent's work phone (____) _____

If the agent I have named above is not willing, reasonably available or able to make decisions for me, I choose the following person to be my agent:

If the person I have named as Choice # 2 is not willing, reasonably available or able to make decisions for me, I choose the following person to be my agent:

Choice # 2 to be my agent

Choice # 3 to be my agent



Name _____

Name _____

Title or Relationship to me _____

Title or Relationship to me _____

Address _____

Address _____

Home Phone (____) _____

Home Phone (____) _____

Work Phone (____) _____

Work Phone (____) _____

You may change your mind later about who you want to be your agent. If you want to stop the agent you have named from making decisions for you, you must tell your primary physician or fill in these blanks:

I do **not** want _____ to be my agent. _____

My signature

Date you filled out and signed this section _____

Any time you cancel, replace or change this form you should give copies of the changed or new form to everyone who has a copy of your original form.





Your agent's power:

When your agent can start making decisions for you: (Check only one box: A or B)

A. My agent can make decisions only when my primary physician or a judge decides that I am too sick to make my own health care decisions.

OR

B. My agent can start making health care decisions for me right away, but this does not mean I have given up the right to make my own decisions if I am still able and willing to make my own decisions. When my agent makes a health care decision for me, I will be told, if possible, about that decision before it is carried out unless I say I do not want to know. If I disagree with that decision and am still able to decide, I can make a different decision. As long as I am able, I can end my agent's right to make decisions for me, change my agent or make my own decisions. If I want to end my agent's right to make decisions for me, I must tell my primary physician or put my decision in writing and sign it with the date of my signature.

Nominating a guardian:

A guardian is a person chosen by a court to make decisions about your personal care. These decisions can include not only health care, but other decisions such as where you will live and how your personal needs will be met. If you wish, you may ask that a court assign your agent as your guardian, if appointment of a guardian should become necessary. Check the box below to nominate your agent to be your guardian, if a judge needs to appoint a guardian for you.

I nominate my agent to be my guardian if a judge needs to appoint a guardian for me.

If you want to nominate someone other than your agent to be your guardian, you may fill in the section below.

If a judge needs to appoint a guardian for me, I nominate the person named below as my guardian:

Name _____ Title or Relationship to me _____

Address _____

Home Phone (____) _____ Work Phone (____) _____





Part 2 – Special Instructions

Instructions if you did not name an agent in Part 1:

If you did not name an agent in Part 1, you should fill out this Part to state what you want for care if you become too sick to make your choices known.

OR

Instructions if you did name an agent in Part 1:

If you named an agent in Part 1, you do not have to fill out this part of the form. If you want your agent to make all of your health care decisions, DO NOT fill out this part of the form. Your agent will make decisions in your best interests, including decisions to refuse treatment. However, you may fill out this part if you want to give special directions to your agent about your wishes, such as when you are near death, in a permanent coma or no longer able to make your own decisions. You may also cross out or add words. It is best if you put your initials and date next to any changes you make so everyone knows the changes were your decision. If you complete this part, your physician and others will follow these instructions and your agent cannot make a different decision. You may also write your wishes on another piece of paper, sign it, date it, and keep it with this form.

Life-Sustaining Treatment Choices:



You may check one of the two boxes below to show your choice about getting treatments that would keep you alive:

<input type="checkbox"/> <u>Choice not to be kept alive</u> <p>I do not want treatment to keep me alive if my physician decides that either of the following is true;</p> <p>(i) I have an illness that will not get better, cannot be cured, and will result in my death quite soon (sometimes referred to as a terminal condition),</p> <p>OR</p> <p>(ii) I am no longer aware (unconscious) and it is very likely that I will never be conscious again (sometimes referred to as a persistent vegetative state).</p>	<input type="checkbox"/> <u>Choice to be kept alive</u> <p>I want to be kept alive as long as possible within the limits of generally accepted health care standards, even if my condition is terminal or I am in a persistent vegetative state.</p>
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Life-Sustaining Treatment Choices:

You may also check one of the two boxes below to show your choice about treatment that would keep you alive if, in the future, you have late stage Alzheimer’s disease or other severe dementia. These choices will not limit the authority under state law for your agent, surrogate, guardian or physician to make treatment choices if you are unable to make your own decisions and are **not** in late stage Alzheimer’s disease or other severe dementia.

<input type="checkbox"/> <u>Choice not to be kept alive</u> If my physician and a second physician decide that I am in the late stage of Alzheimer’s disease* or other severe dementia, I do not want treatment to keep me alive.	<input type="checkbox"/> <u>Choice to be kept alive</u> I want treatment to keep me alive as long as possible within the limits of generally accepted health care standards, even if my physician and a second physician decide that I am in the late stage of Alzheimer’s disease or other severe dementia.
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* Only a physician can determine that someone is in the late stage of Alzheimer’s disease. People in the late stages of Alzheimer’s disease generally have a number of the following characteristics: loss of the ability to respond to their environment; loss of the ability to speak; loss of the ability to control movement; loss of the capacity for recognizable speech, although words or phrases may occasionally be uttered; needing help with eating and toileting; general incontinence of urine; loss of the ability to walk without assistance, then the ability to sit without support, then the ability to smile, and the ability to hold their head up; reflexes become abnormal; muscles grow rigid; and swallowing is impaired.

Tube Feeding: You may check one of the two boxes below to show your choice about tube feeding or having water and nutrition fed into your body through an IV or tube (artificial nutrition and hydration):

<input type="checkbox"/> Artificial nutrition and hydration should not be given, or should be stopped, based on the other life-sustaining treatment choices I made about keeping me alive on Pages 6 and 7.	<input type="checkbox"/> Artificial nutrition and hydration should be given regardless of my condition.
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Relief from Pain: You may check the box or fill in the blanks below to show your choice about relief of pain or discomfort.

<input type="checkbox"/> I want treatment for relief of pain or discomfort to be given at all times, even if it shortens the time until my death or makes me drowsy, unconscious or unable to do other things.	These are my wishes about relief of pain or discomfort: <hr/> <hr/> <hr/> <hr/>
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Other Directions:

You may give more directions or add any other treatment choices in the space below:







Part 3 — Primary Physician

This section is optional. Fill out this part only if you wish to name your primary physician today.

Name of my primary physician: _____

Address: _____ Phone: _____

I want any agent I named in Part 1 to talk with this physician about my health care. If the physician I have named above is not willing, reasonably available or able to carry out my wishes, I want the agent I named in Part 1 to talk with the physician listed below:

Name of physician: _____

Address: _____ Phone: _____



If you want your agent or those making decisions for you to speak with a nurse practitioner or physician assistant before making a decision, you may complete the following section:

Name of nurse practitioner or physician assistant: _____

Address: _____ Phone: _____





Part 4 – Donation of Body, Organs or Tissues at Death

This section is optional. Fill out this part only if you want to give directions about donating your body, organs or tissues after your death.

I do **NOT** wish to donate any organs, tissues or parts.

I have checked below my choices about donating my body, organs or tissues after death. I have spoken with my family so that they will not object to my wishes after I die.

I give my body. **OR**

I give any needed organs, tissues or parts. **OR**

I give only the following organs, tissues, or parts:



My gift is for the following purposes (you may check any number of boxes):

My gift is for transplant or therapy for another person, to be chosen based on generally accepted health care standards.

My gift is for research and education. My preference, if any, is to give my body, organs, or tissues to the following hospital, medical school, or physician:

Name _____

Address _____





I understand that I may need to contact the hospital, medical school, or physician before I die in order for them to accept my body, organs or tissues after my death.





Part 5 – Instructions About Funeral and Burial Arrangements


This section is optional. Fill out this part only if you wish to give special instructions about your funeral or burial arrangements here.

I hope that my family will follow my wishes after I die as noted below.

I choose _____ to have custody and control of my body after my death with the right to decide everything about my funeral and burial.

OR

I want my family to know these are my wishes about: burial, cremation, funeral, or memorial service.
(Fill in)



If you plan to die at home, talk with your physician and funeral director about your plans. When you die, your family or agent should call your physician and the funeral home you have chosen. The funeral home staff will pick up your body from your home.





Part 6—Signing the Form

If you have filled out any part of this form, you must sign and date the form on this page. You must also have two other adults sign as witnesses at the same time you sign the form. It is recommended that your agent not sign as a witness. You do not need to have a Notary Public sign your Advance Directive form to make it legal in Maine. However, if you travel or live part of the year out-of-state, it would be wise to have it signed by a Notary. Some states require this. You can find this service under Notary Public in the phone book. Most banks also have Notaries Public and will usually notarize papers for bank customers when asked. The Notary Acknowledgment may be done at any time after you sign this form.

If you are in a hospital or residential healthcare facility, have an infectious disease and are confined to a room or ward where isolation precautions prevent the physical presence of individuals or documents necessary for filling out and signing this form, you may be able to complete the form using audiovisual technology. You can find details on that process at 18-C M.R.S. § 5-803-A, located at <https://legislature.maine.gov/statutes/18-C/title18-Csec5-803-A.html>.

Sign and date the form here:

Sign your name: _____ Your Address: _____

Print your name: _____

Date: _____

First witness:

Signature: _____ Address: _____

Print your name: _____

Date: _____

Second witness:

Signature: _____ Address: _____

Print your name: _____

Date: _____

Notary Acknowledgment.

Then personally appeared the above named _____, known to me or who presented satisfactory evidence of his/her identity, and acknowledged this Advance Directive as his/her free act and deed before me.

Notary signature: _____ Date: _____

Printed name: _____ Notary Public State of: _____ Commission Exp.: _____

Make sure to tell people. Tell your family members, physicians and others close to you what you have decided. **You should talk to the agent(s) you have chosen to make sure that they understand your wishes and are willing to carry them out.** Give a copy of this form to your physician, to any place where you get health care, and to any agent(s) you have chosen in Part 1. Please be sure to list the people who have copies of this form on the front page.





Canceling or changing the form.

Part 1: You may end your agent's right to make decisions while you are still able to make those decisions by telling your primary physician or putting your decision in writing and attaching it to this form. If you want to name a new agent, you must put that instruction in writing and sign it in front of two witnesses who must also sign their names.

Parts 2-7: You may cancel any other part of this form or change your instructions in the other parts of this form while you are still able to make those decisions. It is best to do so by (1) writing on this form, (2) writing on another piece of paper and attaching it to this form, or (3) completing a new form. Any of those written changes should be signed and dated by you.





Part 7—Instructions to Emergency Medical Services (ambulance crews) about what to do if your heart or breathing stops.

This section is optional. If you do not want ambulance crews to revive you if your heart or breathing stops, you and your physician (**or** nurse practitioner **or** physician assistant) must both complete and sign this part.

Instructions for Part 7:

- If I stop breathing or my heart stops, I do not want the Emergency Medical Services (ambulance crews) to try to revive me. My physician (**or** nurse practitioner **or** physician assistant) and I have discussed this and signed the special form on the next page. I understand that this decision will not prevent me from receiving other emergency care, or comfort care from health care workers before I die.
- I understand that the form goes into effect when I have signed it **AND** it is signed by my physician (**or** nurse practitioner **or** physician assistant).
- I understand that this directive will not be followed unless my family, caretaker or I give the signed form on the next page to Emergency Medical Services (ambulance crews), and that it is solely my responsibility to make sure they see it.
- I understand that I should carry the signed form with me unless I wear health alert jewelry, such as MedicAlert, that also tells people that I do not want to be revived if my heart or breathing stops (Please call Maine Emergency Medical Services at 207-626-3860 to see if there are other Maine EMS approved health alert jewelry companies).
- I understand that if any health care provider has any doubts about what I want, they will try to restart my heart or breathing.
- I understand that I may revoke this directive at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry. I can also tell the ambulance crews that I have changed my mind.
- I understand that should I change my mind, it is my responsibility to tell my physician (**or** nurse practitioner **or** physician assistant) and other people who have copies of the signed form.
- If I want my agent to make this decision later, my agent should take the form available at: <http://www.maine.gov/dps/ems> to my physician (**or** nurse practitioner **or** physician assistant) when it is time to make the decision.



If you complete and sign this section, put the original in a safe place and be sure to give copies to ambulance crews, your family, your caregivers, and your physician.



DO-NOT-RESUSCITATE (DNR) DIRECTIVE

This section is optional. If you do not want ambulance crews to revive you if your heart or breathing stops, you **and** your physician (**or** nurse practitioner **or** physician assistant) must complete and sign this form.

FOR PATIENT TO COMPLETE after consultation with his or her health care provider:

In the event that my heart or breathing stops and I am unable to speak for myself, I, _____ (printed name) direct that no efforts be taken to restart my heart or breathing and that Emergency Medical Services (ambulance crews) if notified, honor my directive. I have come to this decision after considering my condition and prognosis and the potential risks, burdens and benefits of refusing efforts to restart my heart or breathing.

I understand that I may change my mind at any time by destroying this form and removing any Maine EMS approved Do-Not-Resuscitate jewelry, such as MedicAlert. I will also tell my physician (**or** nurse practitioner **or** physician assistant) and other caregivers if I change my mind.

I understand that this form is not valid until my physician (**or** nurse practitioner **or** physician assistant) **and** I have signed it.

I understand that in a hospital, nursing home, hospice or home health setting, federal law requires that my physician must include a specific DNR order in my medical record or plan of care, even if we have both signed this form.

No expiration date **OR** Expires on _____

Patient Signature

Date Signed

FOR PHYSICIAN, PHYSICIAN ASSISTANT OR NURSE PRACTITIONER TO COMPLETE:

By my signature I affirm that:

(i) After meeting with this patient and discussing this decision, I am satisfied that the patient understands the potential risks, burdens and benefits of refusing resuscitative interventions in light of the patient's medical condition; and (ii) I believe that the patient has made a voluntary informed decision about resuscitation and I agree to comply with that decision. I will tell any health care providers providing care under my authority to comply with this decision.

Signature and license level (MD, DO, PA or NP)

Date Signed

Printed Name

Telephone Number





THIS FORM IS ENDORSED BY MAINE EMERGENCY MEDICAL SERVICES

