



# ADVANCE DIRECTIVE Planning Guide

Information Provided as a Community Service

**Renown**<sup>®</sup>  
HEALTH

# If a medical tragedy strikes, you have the **RIGHT TO CHOOSE** what medical care you do or do not want.

It is best if you make this important decision and discuss it with your family while you are healthy and competent. The easiest way to make sure that your wishes will be followed is for you to write what is known as a living will. It states the kind of medical care that should be received if you become unable to make your own decisions.

According to Nevada's Right to Die law (Chapter 449 of Nevada Revised Statutes), your doctor is required to follow your instructions exactly as you have written them in your declaration or living will. In addition, it allows your family to make decisions about life-sustaining medical treatments if you're unable to communicate.

## **What is an advance directive?**

An advance directive is a written document stating how you want medical decisions made if you lose the ability to make decisions for yourself. It allows you to state your choices for healthcare or to name someone to make those choices for you if you become unable to make decisions about your medical treatment.

## **The two most common advance directives are:**

**Living Will:** In Nevada, living wills are called declarations, and they state the kind of medical care you want or do not want if you become unable to make decisions on your own. It is called a living will because it takes effect while you are still living. You can complete a preprinted form, draw up your own form, or write a statement of treatment preferences. You may want to speak to an attorney or doctor to be certain you have completed the living will in a way that your wishes will be understood and followed.

**Durable Power of Attorney for Healthcare:** A durable power of attorney for healthcare is a signed, dated, and witnessed paper naming another person as your authorized spokesperson to make medical decisions for you if you should become unable to make them for yourself. You can also include instructions about any treatment you want to avoid.

## **Do I have to write an advance directive?**

No. It is entirely up to you.

## **Which is better: a living will or a durable power of attorney for healthcare?**

In some states, laws make it better to have one or the other. It may also be possible to have both or to combine them in a single document that describes treatment choices in a variety of situations (ask your doctor about these) and name someone to make decisions for you should you be unable to make decisions for yourself.

## **Can I change my mind after I write a living will or healthcare power of attorney?**

Yes, you have the right to change or cancel an advance directive at any time. Any change or cancellation should be written, signed and dated in accordance with state law, and copies should be given to your family doctor as well to others whom you may have given copies of the original. If you wish to cancel an advance directive while you are in the hospital, you should notify your doctor, your family and others who may need to know that you have changed your living will or power of attorney for healthcare.

## **What if I fill out an advance directive in one state and am hospitalized in another?**

The law honoring an advance directive from another state is unclear. However, an advance directive tells your wishes regarding medical care and may be honored wherever you are if it's available to medical staff. If you spend a great deal of time in more than one state, consider having your advance directive meet the laws of both states to the largest extent possible.

## **What should I do with my advance directive if I choose to have one?**

Make sure that someone, such as your lawyer or family member, knows that you have an advance directive and where it is located. You might also consider the following:

- If you have a durable power of attorney, give a copy or the original to your agent or proxy. Your agent or proxy is any person authorized to make healthcare decisions on your behalf.

- Ask your doctor to make your advance directive part of your permanent medical record.
- Keep a second copy of your advance directive in a safe place where it can be found easily if it is needed.
- Keep a small card in your purse or wallet that states that you have an advance directive, where it is located and who you've designated as your agent or proxy. By law, when you enter a hospital or skilled nursing hospital, you should be asked whether you have an advance directive or living will.

### Some questions to consider

- Under what conditions would you want life-sustaining procedures to be provided?
- Under what conditions would you want life-sustaining procedures withheld or withdrawn?
- What would you consider burdensome treatment?
- If you are dying or in an incurable or irreversible condition with no expectation of recovery, would you want...
  - Antibiotics? Under what conditions?
  - Cardio-pulmonary resuscitation (CPR)? Under what conditions?
  - Do you want nutritional support if you are unable to swallow or eat your meals? If you are in a persistent vegetative state?
  - Feeding by tubes to your stomach (nasogastric/gastrostomy)? Under what conditions?
  - Intravenous fluids? Under what conditions?
  - Kidney dialysis? Temporary or permanent treatment? Under what conditions?
  - Support by respirator? Under what conditions?
  - Blood and blood products? Under what conditions?
  - Surgery? Life prolonging? Comfort measure only?
  - Return to hospital from hospice care at home or from nursing home? Under what conditions?
  - Hospice care? Palliative care only? Comfort measure only?
  - Other concerns: \_\_\_\_\_

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**For additional information regarding Advance Directives and Durable Powers of Attorney, contact:**

**Renown Regional Medical Center**  
Social Services at 775-982-4125  
Spiritual Care Services at 775-982-7676

**Renown South Meadows  
Medical Center**  
Social Services at 775-982-7033

**Renown Skilled Nursing**  
Social Services at 775-982-5186

**Renown Home Care**  
Social Services at 775-982-5860

**Other Community Resources:**

**Washoe County Senior Services  
Senior Law Project**  
775-334-3050  
1155 E 9th Street, Suite 25 (Sutro & 9th)  
Reno, NV 89512  
[washoecounty.us/seniorsrv/index.htm](http://washoecounty.us/seniorsrv/index.htm)

**Legislative Counsel Bureau,  
Capitol Complex**  
(Can provide copies of Nevada law)  
775-684-6827  
401 S Carson Street  
Carson City, NV 89710  
[leg.state.nv.us](http://leg.state.nv.us), see Advance Directives  
under Nevada Revised Statutes

**Caring Connections**  
800-658-8898  
1731 King St., Suite 100  
Alexandria, VA 22314  
[caringinfo.org](http://caringinfo.org)

**Complaints and grievances may be addressed to:**

**Bureau of Healthcare Quality and Compliance**  
775-684-1030  
727 Fairview Drive, Suite E  
Carson City, NV 89701

## **Renown Health's Advance Directive Policies**

Each patient admitted to Renown Health will be given a copy of the patient's rights and responsibilities, and the patient access representative will familiarize the patient with its contents. The patient access representative will also ascertain whether or not the patient currently has an advance directive. If the patient does have a living will or durable power of attorney for healthcare, the document(s) will be scanned into the patient's electronic medical record as well as placed in the patient's medical chart.

If the patient does not have an advance directive, the patient access representative will provide the patient with the advance directive forms to complete, should they choose to do so. If requested, Renown Health Social Services will offer assistance with advance directive forms. Patients may also seek assistance from community resources, such as the Washoe County Senior Law Project or Washoe Legal Services. If the patient cannot understand the contents of the form for any reason, Renown Health Social Services will utilize translation services or other assistive devices as necessary to ensure the patient is able to complete an advance directive.

If the patient has an advance directive and has provided Renown Health with a copy of the directive, it will be honored by the system regardless of the range of medical conditions or procedures stipulated within the document. However, there may be individual doctors with admitting/service privileges who, due to religious, ethical or moral conscience objections, may be unwilling or unable to honor a patient's advance directive. If this were ever the case, the doctor and/or hospital will take all reasonable steps to transfer the patient to a doctor who will honor the patient's advance directive per NRS 449.628.

Renown Health will not discriminate against an individual based on whether or not they have an advance directive.

Copies of an advance directive are available through the Patient Access Department. All new employees are informed of patient's rights and responsibilities during new employee orientation and refamiliarized with these rights on an annual basis as a part of their ongoing safety training. Renown Health also provides education regarding patient's rights and responsibilities and advance directives to the community annually per the requirements outlined in the Patient Self Determination Act enacted by the 101st Congress.





# Instructions and Forms for **ADVANCE DIRECTIVES**

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HEALTH

# Instructions for Completion of **ADVANCE DIRECTIVES**

The document titled Declaration is the one traditionally known as the Directive to Physician or Living Will. You may complete a declaration directing your doctor to withhold or withdraw life-sustaining treatment.

The declaration allows you to document what kind of life-saving measures you either want or do not want done if you have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will cause death within a relatively short time.

When you complete a Declaration, you should give copies to your family, attorney and primary doctor.

## **Durable Power of Attorney for Healthcare Decisions**

This document allows you to state what you want done in certain life-threatening circumstances, and who will serve as your Attorney-In-Fact, and any alternates you name. It is required that you share this document with your Attorney-In-Fact and any alternates you name. You should also consider sharing this with your family, attorney and your primary doctor. There are provisions for witnesses and for a notary of which you must use at least one.

The Durable Power of Attorney for Healthcare Decisions as provided by NRS 162A.780 must be witnessed by two adults who know you personally. Neither witness may be:

1. The attending doctor (provider of healthcare);
2. An employee of the attending doctor or of the hospital or any other health facility in which you are a patient;
3. The Attorney-In-Fact; and
4. At least one of the witnesses needs to be unrelated to you by blood, marriage or adoption, and is not entitled to any part of your estate.

The Durable Power of Attorney may be notarized by a Renown Health notary. The Department of Social Services is available to answer questions. However, we strongly recommend that the appropriate advice of a qualified attorney be sought out if a simple answer cannot be provided by a Renown Health employee.



Your Declaration and Durable Power of Attorney for Healthcare Decisions are valid in other states provided they are in compliance with the state's laws.

You may revoke the declaration by informing your family, attorney and doctor if you no longer want the declaration.

Declarations and Durable Power of Attorney for Healthcare Decisions can be obtained through the Patient Access or Social Services Departments.

## **Durable Power of Attorney for Healthcare Decisions**

**Warning to person executing this document:** This is an important legal document. It creates a durable Power of Attorney for Healthcare. Before executing this document, you should know these important facts:

1. This document gives the person you designate as your Attorney-In-Fact the power to make healthcare decisions for you. This power is subject to any limitations or statement of your desires that you include in this document. The power to make healthcare decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service or procedure as well as to maintain, diagnose or treat a physical or mental condition. You may state in this document any types of treatment or placements that you do not desire.
2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in your best interests.
3. Except as you otherwise specify in this document, the power of the person you designate to make healthcare decisions for you may include the power to consent to your doctor not to give treatment or to stop treatment that would keep you alive.
4. Unless you specify a shorter period in this document, this power will exist indefinitely from the date you execute this document and, if you are unable to make healthcare decisions for yourself, this power will continue to exist until the time when you become able to make healthcare decisions for yourself.
5. Notwithstanding this document, you have a right to make medical and other healthcare decisions for yourself so long as you can give informed consent with respect to the particular decisions. In addition, no treatment may be given to you over your objection, and healthcare necessary to keep you alive may not be stopped if you object.

6. You have the right to revoke the appointment of the person designated in this document to make healthcare decisions for you by notifying that person of the revocation orally or in writing.
7. You have the right to revoke the authority granted to the person designated in this document to make healthcare decisions for you by notifying the treating doctor, hospital or other provider of healthcare orally or in writing.
8. The person designated in this document to make healthcare decisions for you has the right to examine your medical records and to consent to their disclosures unless you limit this right in the document.
9. This document revokes any prior Durable Power of Attorney for Healthcare.
10. If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

## 1. Designation of Healthcare Agent

I, \_\_\_\_\_ (insert your name) do hereby designate and appoint:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

as my Attorney-In-Fact to make healthcare decisions for me as authorized in this document.

Insert the name and address of the person you wish to designate as your Attorney-In-Fact to make healthcare decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your Attorney-In-Fact: (1) your treating provider of healthcare; (2) an employee of your treating provider of healthcare; (3) an operator of a healthcare facility; or (4) an employee of an operator of a healthcare facility.

## 2. Creation of a Durable Power of Attorney for Healthcare

By this document, I intend to create a Durable Power of Attorney by appointing the person designated above to make healthcare decisions for me. This Power of Attorney shall not be affected by my subsequent incapacity.

## 3. General Statement of Authority Granted

In the event that I am incapable of giving informed consent with respect to healthcare decisions, I hereby grant to the Attorney-In-Fact named above full power and authority: to make healthcare decisions for me before or after my death, including consent, refusal of consent or withdrawal of consent to any care, treatment, service or procedure to maintain, diagnose or treat a physical or mental condition; to request, review and receive any information, verbal or written, regarding my physical or mental health, including, without limitation, medical and hospital records; to execute on my behalf any releases or other documents that may be required to obtain medical care and/or medical and hospital records, EXCEPT any power to enter into any arbitration agreements or execute any arbitration clauses in connection with admission to any healthcare facility including any skilled nursing facility; and subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.



## 4. Special Provisions and Limitations

Your Attorney-In-Fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization or abortion. If there are any other types of treatment or placement that you do not want your Attorney-In-Fact's authority to give consent for or other restrictions you wish to place on the Attorney-In-Fact's authority, you should list them in the space below. If you do not write any limitations, your Attorney-In-Fact will have the broad powers to make healthcare decisions on your behalf, which are set forth in paragraph 3, except to the extent that there are limits by law.

In exercising the authority under the Durable Power of Attorney for Healthcare, the authority of my Attorney-In-Fact is subject to the following special provisions and limitations: \_\_\_\_\_

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## 5. Duration

I understand that this Power of Attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make healthcare decisions for myself when this Power of Attorney expires, the authority I have granted my Attorney-In-Fact will continue to exist until the time when I become able to make healthcare decisions for myself.

I wish to have this Power of Attorney end on the following date (if applicable):

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## 6. Statement of Desires

With respect to decisions to withhold or withdraw life-sustaining treatment, your Attorney-In-Fact must make healthcare decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your Attorney-In-Fact has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so a court can determine the healthcare decision that is in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.

**If the statement reflects your desires, initial the box next to the statement.**

- 1. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures.
- 2. If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatments not be used.
- 3. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life-sustaining or prolonged treatments not be used.
- 4. Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastro-intestinal tract after all other treatment is withheld.
- 5. I do not desire treatment to be provided and/or continued if the burdens of the treatment outweigh the expected benefits. My Attorney-In-Fact is to consider the relief of the suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.

If you wish to change your answer, you may do so by drawing an “X” through the answer you do not want and circling the answer you prefer.

Other or additional statements of desires: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_



## Designation of Alternate Attorney-In-Fact

You are not required to designate any alternative Attorney-In-Fact, but you may do so. Any alternative Attorney-In-Fact you designate will be able to make the same healthcare decision as the Attorney-In-Fact designated in paragraph 1 in the event that he or she is unable or unwilling to act as your Attorney-In-Fact. Also, if the Attorney-In-Fact designated in paragraph 1 is your spouse, his or her designation as your Attorney-In-Fact is automatically revoked by law if your marriage is dissolved.

If the person designated in paragraph 1 as my Attorney-In-Fact is unable to make health care decisions for me, then I designate the following persons to serve as my Attorney-In-Fact to make healthcare decisions for me as authorized in this document.

Such persons are to serve in the order listed below:

### A. First alternative Attorney-In-Fact

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

### B. Second alternative Attorney-In-Fact

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

## 7. Prior Designations Revoked

I revoke any prior Power of Attorney for Healthcare

## 8. Waiver of Conflict of Interest

If my designated agent is my spouse or is one of my children, then I waive any conflict of interest in carrying out the provisions of this Durable Power of Attorney for Healthcare that said spouse or child may have by reason of the fact that he or she may be a beneficiary of my estate.

## 9. Challenges

If the legality of any provision of this Durable Power of Attorney for Healthcare is questioned by my doctor, my agent or a third party, then my agent is authorized to commence an action for declaratory judgment as to the legality of the provision in question. The cost of any such action is to be paid from my estate. This Durable Power of Attorney for Healthcare must be construed and interpreted in accordance with the laws of the State of Nevada.

## 10. Nomination of Guardian

If, after execution of this Durable Power of Attorney for Healthcare, incompetency proceedings are initiated either for my estate or my person, I hereby nominate as my guardian or conservator for consideration by the court my agent herein named, in the order named.

## 11. Release of Information

I agree to, authorize and allow full release of information by any government agency, medical provider, business, creditor or third party who may have information pertaining to my healthcare, to my agent named herein, pursuant to the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended and applicable regulations.

You must date and sign this Power of Attorney.

I sign my name to this Durable Power of Attorney for Healthcare on \_\_\_\_\_ (date)  
at \_\_\_\_\_ (city), \_\_\_\_\_ (state) \_\_\_\_\_ (signature).

This Power of Attorney will not be valid for making healthcare decisions unless it is either (1) signed by at least two qualified witnesses who are personally known to you and who are present when you acknowledge your signature, or (2) acknowledged before a notary public.

## Certificate of Acknowledgement of Notary Public

You may use acknowledgement before a notary public instead of the statement of witnesses.

State of Nevada                                }  
  }SS.  
County of \_\_\_\_\_ }

On this \_\_\_\_\_ day of \_\_\_\_\_ in the year \_\_\_\_\_, before me,  
\_\_\_\_\_  
(here insert name of notary public)  
personally appeared \_\_\_\_\_ (here insert name of  
principal) personally known to me (or proved to me on the basis of satisfactory evidence)  
to be the person whose name is subscribed to this instrument, and acknowledged that he  
or she executed it. I declare under penalty of perjury that the person whose name is  
ascribed to this instrument appears to be of sound mind and under no duress, fraud, or  
undue influence.

Notary Seal \_\_\_\_\_  
(Signature of notary public)

## Statement of Witnesses

You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as witnesses: (1) a person you designate as Attorney-In-Fact; (2) a provider of healthcare; (3) an employee of a provider of healthcare; (4) the operator of a healthcare facility; (5) an employee of an operator of a healthcare facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged the Durable Power of Attorney 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 provider of healthcare, an employee of a provider of healthcare, the operator of community care facility, nor an employee of an operator of a healthcare facility.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
Residence Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
Residence Address: \_\_\_\_\_

At least one of the above witnesses must also sign the following declaration.

I 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: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
Residence Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Print Name: \_\_\_\_\_  
Residence Address: \_\_\_\_\_

## Declaration – Directive to Physician

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending doctor, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending doctor, pursuant to NRS 449.535 to 449.690 inclusive, to withhold or withdraw my treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include this statement in this declaration, you must initial the statement box provided:

Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by the way of the gastro-intestinal tract after all other treatment is withheld pursuant to this declaration.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

This declarant voluntarily signed this writing in my presence.

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

(Added to NRS by 1977,760; A 1991, 633; 1993, 2790)