The Five Wishes Document

Making your wishes known for end of life care

Presenters

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Five Wishes

What is the Five Wishes Document?

- It is an advance directive
- An advance directive is a written statement of a person's wishes regarding medical treatment, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor or others

Five Wishes

What is the Five Wishes Document?

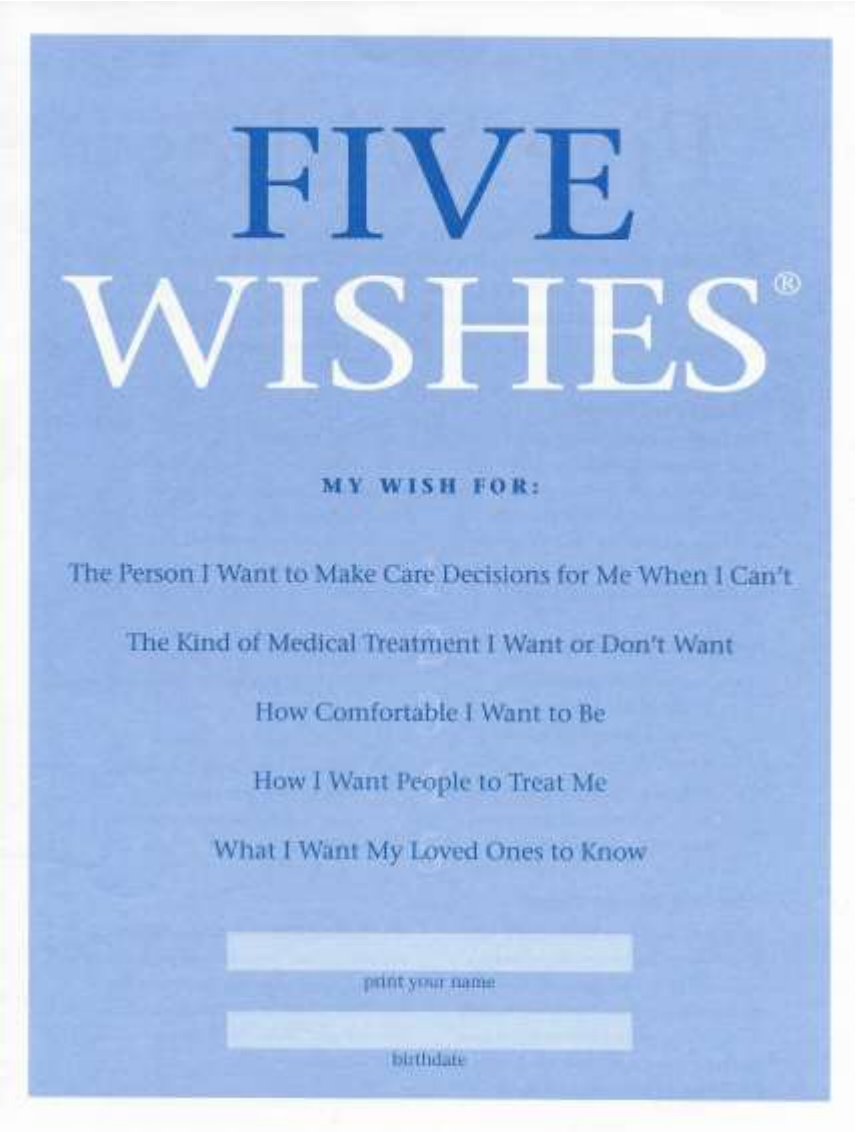
- Names another person to be your agent & speak on your behalf, with up to two additional people as backup
- Allows you to be specific about the types of treatment you want or may not want
- The Five Wishes also addresses a person's emotional, spiritual & personal wishes which makes it different from other advance directives

Five Wishes

The History of the Five Wishes

- It was created by attorney Jim Towey
- He was the attorney for Mother Teresa & volunteered for her as well
- Through his work with Mother Teresa he saw the need for people to plan for their future care, so he created the Five Wishes
- The Five Wishes document is copyrighted (will let you know how to order one later in the presentation)

Five Wishes



Obtain a copy at fivewishes.org

Five Wishes

HOPE Hospice & Health Services

Five Wishes

There are many things in life that are out of our hands. This Five Wishes document gives you a way to control something very important—how you are treated if you get seriously ill. It is an easy-to-complete form that lets you say exactly what you want. Once it is filled out and properly signed it is valid under the laws of most states.

What Is Five Wishes?

Five Wishes is the first living will that talks about your personal, emotional and spiritual needs as well as your medical wishes. It lets you choose the person you want to make health care decisions for you if you are not able to make them for yourself. Five Wishes lets you say exactly how you wish to be treated if you get seriously ill. It was written with the help of The American Bar Association's Commission on Law and Aging, and the nation's leading experts in end-of-life care. It's also easy to use. All you have to do is check a box, circle a direction, or write a few sentences.

How Five Wishes Can Help You And Your Family

- It lets you talk with your family, friends and doctor about how you want to be treated if you become seriously ill.
- Your family members will not have to guess what you want. It protects them if you become seriously ill, because they won't have to make hard choices without knowing your wishes.
- You can know what your mom, dad, spouse, or friend wants. You can be there for them when they need you most. You will understand what they really want.

How Five Wishes Began

For 12 years, Jim Towey worked closely with Mother Teresa, and, for one year, he lived in a hospice she ran in Washington, DC. Inspired by this first-hand experience, Mr. Towey sought a way for patients and their families to plan ahead and to cope with serious illness. The result is Five Wishes and the response to it has been overwhelming. It has been featured on CNN and NBC's Today Show and in the pages of *Time* and *Money* magazines. Newspapers have called Five Wishes the first "living will with a heart and soul." Today, Five Wishes is available in 27 languages.

Five Wishes

Who Should Use Five Wishes

Five Wishes is for anyone 18 or older — married, single, parents, adult children, and friends. More than 20 million people of all ages have already used it. Because it works so well, lawyers, doctors, hospitals and hospices, faith communities, employers, and retiree groups are handing out this document.

Five Wishes States

If you live in the **District of Columbia** or one of the **42 states** listed below, you can use Five Wishes and have the peace of mind to know that it substantially meets your state's requirements under the law:

Alaska	Illinois	Montana	South Carolina
Arizona	Iowa	Nebraska	South Dakota
Arkansas	Kentucky	Nevada	Tennessee
California	Louisiana	New Jersey	Vermont
Colorado	Maine	New Mexico	Virginia
Connecticut	Maryland	New York	Washington
Delaware	Massachusetts	North Carolina	West Virginia
Florida	Michigan	North Dakota	Wisconsin
Georgia	Minnesota	Oklahoma	Wyoming
Hawaii	Mississippi	Pennsylvania	
Idaho	Missouri	Rhode Island	

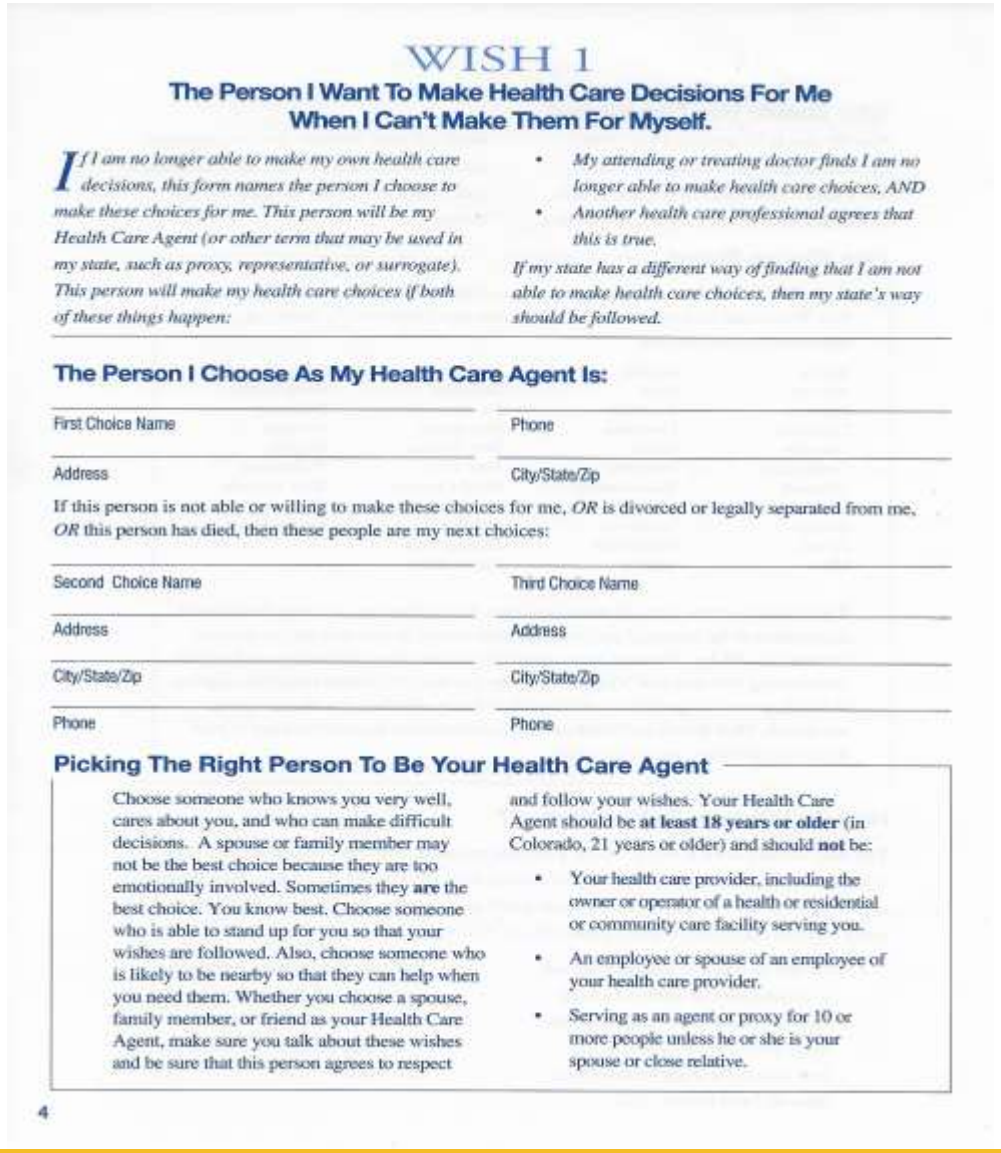
If your state is not one of the 42 states listed here, Five Wishes does not meet the technical requirements in the statutes of your state. So some doctors in your state may be reluctant to honor Five Wishes. However, many people from states not on this list do complete Five Wishes along with their state's legal form. They find that Five Wishes helps them express all that they want and provides a helpful guide to family members, friends, care givers and doctors. Most doctors and health care professionals know they need to listen to your wishes no matter how you express them.

How Do I Change To Five Wishes?

You may already have a living will or a durable power of attorney for health care. If you want to use Five Wishes instead, all you need to do is fill out and sign a new Five Wishes as directed. As soon as you sign it, it takes away any advance directive you had before. To make sure the right form is used, please do the following:

- Destroy all copies of your old living will or durable power of attorney for health care. Or you can write "revoked" in large letters across the copy you have. Tell your lawyer if he or she helped prepare those old forms for you. *AND*
- Tell your Health Care Agent, family members, and doctor that you have filled out a new Five Wishes. Make sure they know about your new wishes.

Five Wishes



WISH 1

The Person I Want To Make Health Care Decisions For Me When I Can't Make Them For Myself.

If I am no longer able to make my own health care decisions, this form names the person I choose to make these choices for me. This person will be my Health Care Agent (or other term that may be used in my state, such as proxy, representative, or surrogate). This person will make my health care choices if both of these things happen:

- *My attending or treating doctor finds I am no longer able to make health care choices, AND*
- *Another health care professional agrees that this is true.*

If my state has a different way of finding that I am not able to make health care choices, then my state's way should be followed.

The Person I Choose As My Health Care Agent Is:

First Choice Name

Phone

Address

City/State/Zip

If this person is not able or willing to make these choices for me, *OR* is divorced or legally separated from me, *OR* this person has died, then these people are my next choices:

Second Choice Name

Third Choice Name

Address

Address

City/State/Zip

City/State/Zip

Phone

Phone

Picking The Right Person To Be Your Health Care Agent

Choose someone who knows you very well, cares about you, and who can make difficult decisions. A spouse or family member may not be the best choice because they are too emotionally involved. Sometimes they **are** the best choice. You know best. Choose someone who is able to stand up for you so that your wishes are followed. Also, choose someone who is likely to be nearby so that they can help when you need them. Whether you choose a spouse, family member, or friend as your Health Care Agent, make sure you talk about these wishes and be sure that this person agrees to respect and follow your wishes. Your Health Care Agent should be **at least 18 years or older** (in Colorado, 21 years or older) and should **not** be:

- Your health care provider, including the owner or operator of a health or residential or community care facility serving you.
- An employee or spouse of an employee of your health care provider.
- Serving as an agent or proxy for 10 or more people unless he or she is your spouse or close relative.

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Five Wishes

Wish 1: The person I want to make health care decisions for me when I can't make them for myself

- This person must be at least 18 years old
- Cannot be your health care provider
- Cannot be an employee or spouse of an employee of a health care provider
- Someone serving as a proxy for 10+ people

Five Wishes

Wish 1: The person I want to make health care decisions for me when I can't make them for myself

- This person should be someone who has a clear understanding of what you want
- Should also be someone you can trust to carry out your wishes
- He or she should be readily available in case of an emergency

Five Wishes

Wish 1: The person I want to make health care decisions for me when I can't make them for myself

- On page five it lists various powers you can give your agent
- There is room to add your own specifics
- Direction on what to do if you change your mind regarding your Health Care Agent

Five Wishes

I understand that my Health Care Agent can make health care decisions for me. I want my Agent to be able to do the following: **(Please cross out anything you don't want your Agent to do that is listed below.)**

- Make choices for me about my medical care or services, like tests, medicine, or surgery. This care or service could be to find out what my health problem is, or how to treat it. It can also include care to keep me alive. If the treatment or care has already started, my Health Care Agent can keep it going or have it stopped.
- Interpret any instructions I have given in this form or given in other discussions, according to my Health Care Agent's understanding of my wishes and values.
- Consent to admission to an assisted living facility, hospital, hospice, or nursing home for me. My Health Care Agent can hire any kind of health care worker I may need to help me or take care of me. My Agent may also fire a health care worker, if needed.
- Make the decision to request, take away or not give medical treatments, including artificially-provided food and water, and any other treatments to keep me alive.
- See and approve release of my medical records and personal files. If I need to sign my name to get any of these files, my Health Care Agent can sign it for me.
- Move me to another state to get the care I need or to carry out my wishes.
- Authorize or refuse to authorize any medication or procedure needed to help with pain.
- Take any legal action needed to carry out my wishes.
- Donate useable organs or tissues of mine as allowed by law.
- Apply for Medicare, Medicaid, or other programs or insurance benefits for me. My Health Care Agent can see my personal files, like bank records, to find out what is needed to fill out these forms.
- Listed below are any changes, additions, or limitations on my Health Care Agent's powers.

If I Change My Mind About Having A Health Care Agent, I Will

- Destroy all copies of this part of the Five Wishes form. *OR*
- Tell someone, such as my doctor or family, that I want to cancel or change my Health Care Agent. *OR*
- Write the word "Revoked" in large letters across the name of each agent whose authority I want to cancel. Sign my name on that page.

Five Wishes

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WISH 2

My Wish For The Kind Of Medical Treatment I Want Or Don't Want.

I believe that my life is precious and I deserve to be treated with dignity. When the time comes that I am very sick and am not able to speak for myself, I want the following wishes, and any other directions I have given to my Health Care Agent, to be respected and followed.

What You Should Keep In Mind As My Caregiver

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means that I will be drowsy or sleep more than I would otherwise.
- I do not want anything done or omitted by my doctors or nurses with the intention of taking my life.
- I want to be offered food and fluids by mouth, and kept clean and warm.

What "Life-Support Treatment" Means To Me

Life-support treatment means any medical procedure, device or medication to keep me alive. Life-support treatment includes: medical devices put in me to help me breathe; food and water supplied by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions; dialysis; antibiotics; and anything else meant to keep me alive. If I wish to limit the meaning of life-support treatment because of my religious or personal beliefs, I write this limitation in the space below. I do this to make very clear what I want and under what conditions.

In Case Of An Emergency

If you have a medical emergency and ambulance personnel arrive, they may look to see if you have a **Do Not Resuscitate** form or bracelet. Many states require a person to have a **Do Not Resuscitate** form filled out and signed by a doctor. This form lets ambulance personnel know that you don't want them to use life-support treatment when you are dying. Please check with your doctor to see if you need to have a **Do Not Resuscitate** form filled out.

Five Wishes

Wish 2: My wish for the kind of medical treatment I want or don't want

- What to keep in mind as my caregiver
- What "Life –Support Treatment" means to me
- What to do in case of an emergency; DNR, CPR & POLST Form

Five Wishes

Wish 2: My wish for the kind of medical treatment I want or don't want – Scenarios

- Close to Death
- In a coma & not expected to wake up or recover
- Permanent & severe brain damage, not expected to recover
- In another condition under which I do not wish to be kept alive

Five Wishes

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Here is the kind of medical treatment that I want or don't want in the four situations listed below. I want my Health Care Agent, my family, my doctors and other health care providers, my friends and all others to know these directions.

Close to death:

If my doctor and another health care professional both decide that I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ❑ I want to have life-support treatment.
- ❑ I do not want life-support treatment. If it has been started, I want it stopped.
- ❑ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In A Coma And Not Expected To Wake Up Or Recover:

If my doctor and another health care professional both decide that I am in a coma from which I am not expected to wake up or recover, and I have brain damage, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ❑ I want to have life-support treatment.
- ❑ I do not want life-support treatment. If it has been started, I want it stopped.
- ❑ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

Permanent And Severe Brain Damage And Not Expected To Recover:

If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example, I can open my eyes, but I can not speak or understand) and I am not expected to get better, and life-support treatment would only delay the moment of my death (Choose *one* of the following):

- ❑ I want to have life-support treatment.
- ❑ I do not want life-support treatment. If it has been started, I want it stopped.
- ❑ I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In Another Condition Under Which I Do Not Wish To Be Kept Alive:

If there is another condition under which I do not wish to have life-support treatment, I describe it below. In this condition, I believe that the costs and burdens of life-support treatment are too much and not worth the benefits to me. Therefore, in this condition, I do not want life-support treatment. (For example, you may write "end-stage condition." That means that your health has gotten worse. You are not able to take care of yourself in any way, mentally or physically. Life-support treatment will not help you recover. Please leave the space blank if you have no other condition to describe.)

Five Wishes

The next three wishes deal with my personal, spiritual and emotional wishes. They are important to me. I want to be treated with dignity near the end of my life, so I would like people to do the things written in Wishes 3, 4, and 5 when they can be done. I understand that my family, my doctors and other health care providers, my friends, and others may not be able to do these things or are not required by law to do these things. I do not expect the following wishes to place new or added legal duties on my doctors or other health care providers. I also do not expect these wishes to excuse my doctor or other health care providers from giving me the proper care asked for by law.

WISH 3

My Wish For How Comfortable I Want To Be.

(Please cross out anything that you don't agree with.)

- I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means I will be drowsy or sleep more than I would otherwise.
- If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my care givers to do whatever they can to help me.
- I wish to have a cool moist cloth put on my head if I have a fever.
- I want my lips and mouth kept moist to stop dryness.
- I wish to have warm baths often. I wish to be kept fresh and clean at all times.
- I wish to be massaged with warm oils as often as I can be.
- I wish to have my favorite music played when possible until my time of death.
- I wish to have personal care like shaving, nail clipping, hair brushing, and teeth brushing, as long as they do not cause me pain or discomfort.
- I wish to have religious readings and well-loved poems read aloud when I am near death.
- I wish to know about options for hospice care to provide medical, emotional and spiritual care for me and my loved ones.

WISH 4

My Wish For How I Want People To Treat Me.

(Please cross out anything that you don't agree with.)

- I wish to have people with me when possible. I want someone to be with me when it seems that death may come at any time.
- I wish to have my hand held and to be talked to when possible, even if I don't seem to respond to the voice or touch of others.
- I wish to have others by my side praying for me when possible.
- I wish to have the members of my faith community told that I am sick and asked to pray for me and visit me.
- I wish to be cared for with kindness and cheerfulness, and not sadness.
- I wish to have pictures of my loved ones in my room, near my bed.
- If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.
- I want to die in my home, if that can be done.

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Five Wishes

Wish 3: My wish for how comfortable I want to be

- Addresses how you want pain and other symptoms managed
- Allows you to cross out anything you don't want or agree with

Five Wishes

Wish 4: My wish for how I want people to treat me

- Address how you want others to treat you while you are being cared for, 1:1 contact
- Provides scenarios of various treatment situations, you can cross out any you don't want or agree with

Five Wishes

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WISH 5

My Wish For What I Want My Loved Ones To Know.

(Please cross out anything that you don't agree with.)

- I wish to have my family and friends know that I love them.
- I wish to be forgiven for the times I have hurt my family, friends, and others.
- I wish to have my family, friends and others know that I forgive them for when they may have hurt me in my life.
- I wish for my family and friends to know that I do not fear death itself. I think it is not the end, but a new beginning for me.
- I wish for all of my family members to make peace with each other before my death, if they can.
- I wish for my family and friends to think about what I was like before I became seriously ill. I want them to remember me in this way after my death.
- I wish for my family and friends and caregivers to respect my wishes even if they don't agree with them.
- I wish for my family and friends to look at my dying as a time of personal growth for everyone, including me. This will help me live a meaningful life in my final days.
- I wish for my family and friends to get counseling if they have trouble with my death. I want memories of my life to give them joy and not sorrow.
- After my death, I would like my body to be (circle one): buried or cremated.
- My body or remains should be put in the following location_____.
- The following person knows my funeral wishes: _____.

If anyone asks how I want to be remembered, please say the following about me:

_____

_____

_____

If there is to be a memorial service for me, I wish for this service to include the following (list music, songs, readings or other specific requests that you have):

_____

_____

_____

(Please use the space below for any other wishes. For example, you may want to donate any or all parts of your body when you die. You may also wish to designate a charity to receive memorial contributions. Please attach a separate sheet of paper if you need more space.)

_____

_____

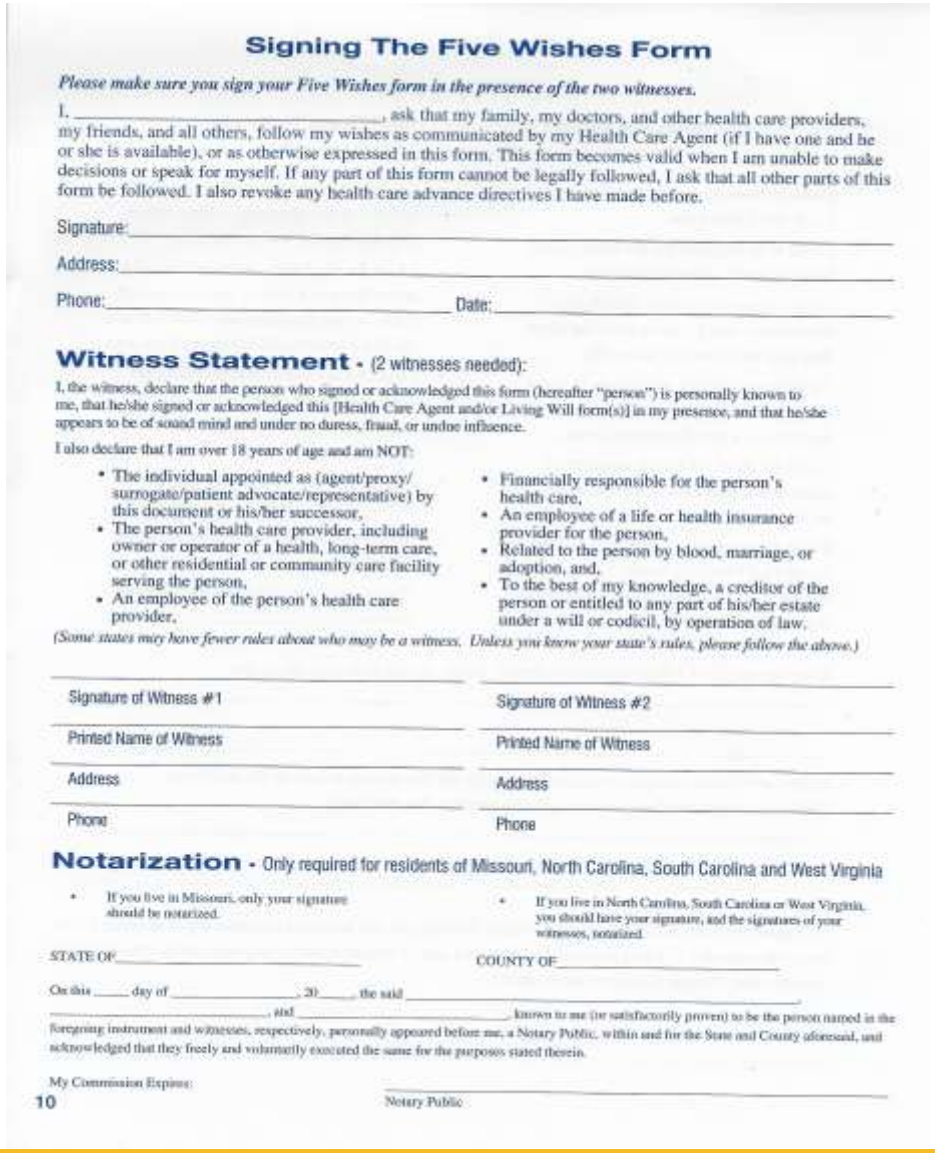
_____

Five Wishes

Wish 5: My wish for what I want my loved ones to know

- Expressions of love
- Requests to grant or be granted forgiveness
- Cremation or burial
- If you want a memorial service or not
- How you want to be remembered
- Cross out any situations that don't apply for you

Five Wishes



Signing The Five Wishes Form

Please make sure you sign your Five Wishes form in the presence of the two witnesses.

I, _____, ask that my family, my doctors, and other health care providers, my friends, and all others, follow my wishes as communicated by my Health Care Agent (if I have one and he or she is available), or as otherwise expressed in this form. This form becomes valid when I am unable to make decisions or speak for myself. If any part of this form cannot be legally followed, I ask that all other parts of this form be followed. I also revoke any health care advance directives I have made before.

Signature: _____

Address: _____

Phone: _____ Date: _____

Witness Statement - (2 witnesses needed):

I, the witness, declare that the person who signed or acknowledged this form (hereafter "person") is personally known to me, that he/she signed or acknowledged this [Health Care Agent and/or Living Will form(s)] in my presence, and that he/she appears to be of sound mind and under no duress, fraud, or undue influence.

I also declare that I am over 18 years of age and am NOT:

- The individual appointed as (agent/proxy/surrogate/patient advocate/representative) by this document or his/her successor,
- The person's health care provider, including owner or operator of a health, long-term care, or other residential or community care facility serving the person,
- An employee of the person's health care provider,
- Financially responsible for the person's health care,
- An employee of a life or health insurance provider for the person,
- Related to the person by blood, marriage, or adoption, and,
- To the best of my knowledge, a creditor of the person or entitled to any part of his/her estate under a will or codicil, by operation of law.

(Some states may have fewer rules about who may be a witness. Unless you know your state's rules, please follow the above.)

Signature of Witness #1	Signature of Witness #2
Printed Name of Witness	Printed Name of Witness
Address	Address
Phone	Phone

Notarization - Only required for residents of Missouri, North Carolina, South Carolina and West Virginia

- If you live in Missouri, only your signature should be notarized.
- If you live in North Carolina, South Carolina or West Virginia, you should have your signature, and the signatures of your witnesses, notarized.

STATE OF _____ COUNTY OF _____

On this ____ day of _____, 20____, the said _____

_____ and _____, known to me (or satisfactorily proven) to be the person named in the foregoing instrument and witnesses, respectively, personally appeared before me, a Notary Public, within and for the State and County aforesaid, and acknowledged that they freely and voluntarily executed the same for the purposes stated therein.

My Commission Expires: _____

Notary Public

Five Wishes

Signing of the Five Wishes

- Must be signed in front of two witnesses
- Witness cannot be:
  - Under 18 years old
  - Your agent listed on the Five Wishes
  - Health Care provider or an employee of the health care provider
  - Financially responsible for your health care

Five Wishes

Signing of the Five Wishes

- Witness cannot be:
  - Employee of a life or health insurance provider for you
  - Related by blood, marriage or adoption
  - Not a creditor of yours or entitled to any part of your estate under a will or codicil, by operation of law
- California does not require the Fives Wishes to be notarized

Five Wishes

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What To Do After You Complete Five Wishes

- Make sure you sign and witness the form just the way it says in the directions. Then your Five Wishes will be legal and valid.
- Talk about your wishes with your health care agent, family members and others who care about you. Give them copies of your completed Five Wishes.
- Keep the original copy you signed in a special place in your home. Do NOT put it in a safe deposit box. Keep it nearby so that someone can find it when you need it.
- Fill out the wallet card below. Carry it with you. That way people will know where you keep your Five Wishes.
- Talk to your doctor during your next office visit. Give your doctor a copy of your Five Wishes. Make sure it is put in your medical record. Be sure your doctor understands your wishes and is willing to follow them. Ask him or her to tell other doctors who treat you to honor them.
- If you are admitted to a hospital or nursing home, take a copy of your Five Wishes with you. Ask that it be put in your medical record.
- I have given the following people copies of my completed Five Wishes:

_____

_____

_____

Residents of Wisconsin must attach the Wisconsin notice statement to Five Wishes.
More information and the notice statement are available at www.agingwithdignity.org or 1-888-594-7437.

Residents of Institutions In California, Connecticut, Delaware, Georgia, New York, North Dakota, South Carolina, and Vermont Must Follow Special Witnessing Rules.

If you live in certain institutions (a nursing home, other licensed long term care facility, a home for the mentally retarded or developmentally disabled, or a mental health institution) in one of the states listed above, you may have to follow special "witnessing requirements" for your Five Wishes to be valid. For further information, please contact a social worker or patient advocate at your institution.

Five Wishes is meant to help you plan for the future. It is not meant to give you legal advice. It does not try to answer all questions about anything that could come up. Every person is different, and every situation is different. Laws change from time to time. If you have a specific question or problem, talk to a medical or legal professional for advice.

Five Wishes Wallet Card

Important Notice to Medical Personnel:
I have a Five Wishes Advance Directive.

Signature

Please consult this document and/or my Health Care Agent in an emergency. My Agent is:

Name

Address City/State/Zip

Phone

My primary care physician is:

Name

Address City/State/Zip

Phone

My document is located at:

Cut Out Card, Fold and Laminate for Safekeeping

Five Wishes

After signing:

- Make copies for all those named as agents, your physician & anyone you feel may need a copy
- Keep the original in a safe but easily accessible place (Not the safety deposit box)
- Fill out the wallet card provided and keep it in your wallet or purse in case of an emergency

Five Wishes

The Five Wishes is a copyrighted document, to obtain a blank copy call:

(888) 5 Wishes

(888) 594-7437

or go to

www.FiveWishes.org

Five Wishes & POLST Form

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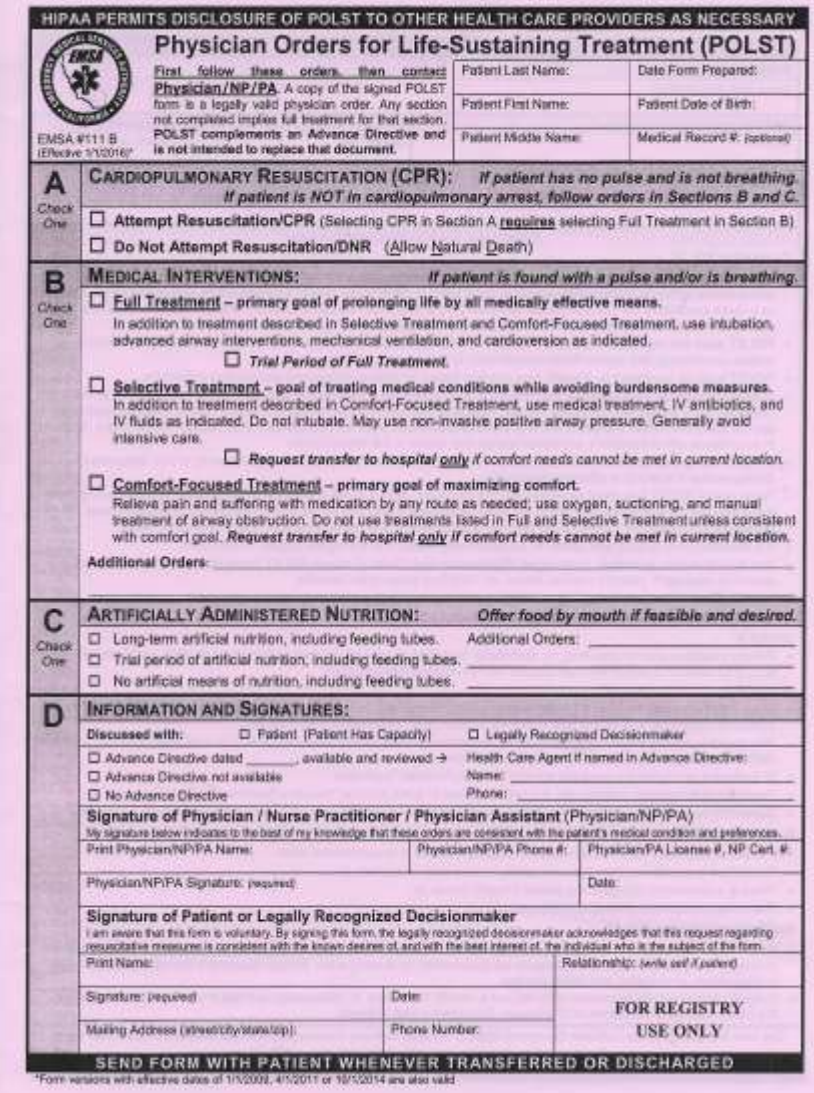


HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Physician Orders for Life-Sustaining Treatment (POLST)

EMSA #111 B (Effective 1/1/2016)*

First follow these orders, then contact Physician/NP/PA. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.

Patient Last Name:	Date Form Prepared:
Patient First Name:	Patient Date of Birth:
Patient Middle Name:	Medical Record #: (optional)

A Check One — **CARDIOPULMONARY RESUSCITATION (CPR):** *If patient has no pulse and is not breathing. If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.*

- ☐ **Attempt Resuscitation/CPR** (Selecting CPR in Section A requires selecting Full Treatment in Section B)
- ☐ **Do Not Attempt Resuscitation/DNR** (Allow Natural Death)

B Check One — **MEDICAL INTERVENTIONS:** *If patient is found with a pulse and/or is breathing.*

- ☐ **Full Treatment – primary goal of prolonging life by all medically effective means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated.
  - ☐ *Trial Period of Full Treatment.*
- ☐ **Selective Treatment – goal of treating medical conditions while avoiding burdensome measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care.
  - ☐ *Request transfer to hospital only if comfort needs cannot be met in current location.*
- ☐ **Comfort-Focused Treatment – primary goal of maximizing comfort.** Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. *Request transfer to hospital only if comfort needs cannot be met in current location.*

Additional Orders: _____

C Check One — **ARTIFICIALLY ADMINISTERED NUTRITION:** *Offer food by mouth if feasible and desired.*

- ☐ Long-term artificial nutrition, including feeding tubes. Additional Orders: _____
- ☐ Trial period of artificial nutrition, including feeding tubes. _____
- ☐ No artificial means of nutrition, including feeding tubes. _____

D — **INFORMATION AND SIGNATURES:**

Discussed with: ☐ Patient (Patient Has Capacity) ☐ Legally Recognized Decisionmaker

- ☐ Advance Directive dated _____, available and reviewed →
- ☐ Advance Directive not available
- ☐ No Advance Directive

Health Care Agent if named in Advance Directive: Name: _____ Phone: _____

Signature of Physician / Nurse Practitioner / Physician Assistant (Physician/NP/PA)

My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.

Print Physician/NP/PA Name:	Physician/NP/PA Phone #:	Physician/PA License #, NP Cert. #
Physician/NP/PA Signature: (required)		Date:

Signature of Patient or Legally Recognized Decisionmaker

I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

Print Name:		Relationship: (write self if patient)
Signature: (required)	Date:	FOR REGISTRY USE ONLY
Mailing Address (street/city/state/zip):	Phone Number:	

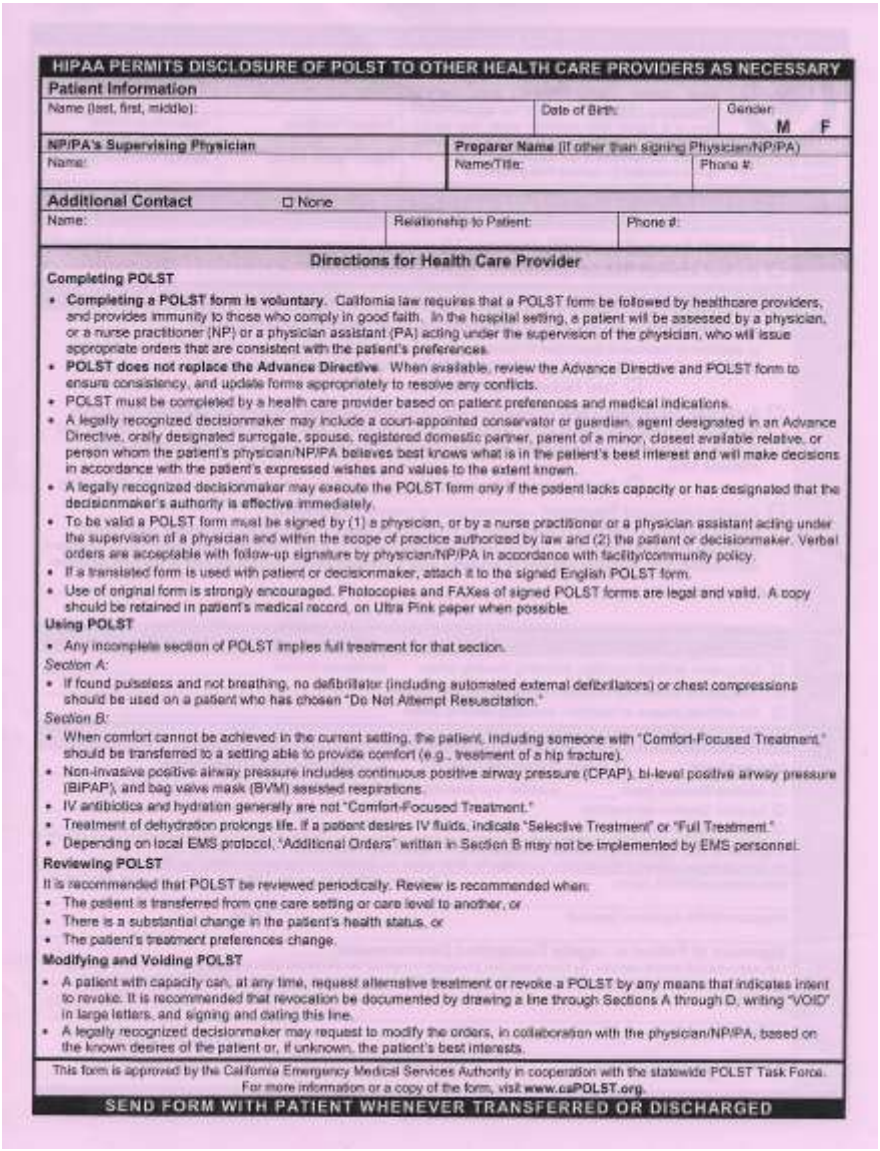
SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

*Form versions with effective dates of 1/1/2009, 4/1/2011 or 10/1/2014 are also valid.

Your doctor can provide you with a POLST form.

Or, click here to download the POLST. (Must be printed on pink paper.)

Five Wishes & POLST Form



HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTH CARE PROVIDERS AS NECESSARY

Patient Information

Name (last, first, middle): | Date of Birth: | Gender: M F

NP/PA's Supervising Physician | **Preparer Name** (if other than signing Physician/NP/PA)

Name: | Name/Title: | Phone #:

Additional Contact ☐ None

Name: | Relationship to Patient: | Phone #:

Directions for Health Care Provider

Completing POLST

- **Completing a POLST form is voluntary.** California law requires that a POLST form be followed by healthcare providers, and provides immunity to those who comply in good faith. In the hospital setting, a patient will be assessed by a physician, or a nurse practitioner (NP) or a physician assistant (PA) acting under the supervision of the physician, who will issue appropriate orders that are consistent with the patient's preferences.
- **POLST does not replace the Advance Directive.** When available, review the Advance Directive and POLST form to ensure consistency, and update forms appropriately to resolve any conflicts.
- POLST must be completed by a health care provider based on patient preferences and medical indications.
- A legally recognized decisionmaker may include a court-appointed conservator or guardian, agent designated in an Advance Directive, orally designated surrogate, spouse, registered domestic partner, parent of a minor, closest available relative, or person whom the patient's physician/NP/PA believes best knows what is in the patient's best interest and will make decisions in accordance with the patient's expressed wishes and values to the extent known.
- A legally recognized decisionmaker may execute the POLST form only if the patient lacks capacity or has designated that the decisionmaker's authority is effective immediately.
- To be valid a POLST form must be signed by (1) a physician, or by a nurse practitioner or a physician assistant acting under the supervision of a physician and within the scope of practice authorized by law and (2) the patient or decisionmaker. Verbal orders are acceptable with follow-up signature by physician/NP/PA in accordance with facility/community policy.
- If a translated form is used with patient or decisionmaker, attach it to the signed English POLST form.
- Use of original form is strongly encouraged. Photocopies and FAXes of signed POLST forms are legal and valid. A copy should be retained in patient's medical record, on Ultra Pink paper when possible.

Using POLST

- Any incomplete section of POLST implies full treatment for that section.

Section A:

- If found pulseless and not breathing, no defibrillator (including automated external defibrillators) or chest compressions should be used on a patient who has chosen "Do Not Attempt Resuscitation."

Section B:

- When comfort cannot be achieved in the current setting, the patient, including someone with "Comfort-Focused Treatment," should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).
- Non-invasive positive airway pressure includes continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations.
- IV antibiotics and hydration generally are not "Comfort-Focused Treatment."
- Treatment of dehydration prolongs life. If a patient desires IV fluids, indicate "Selective Treatment" or "Full Treatment."
- Depending on local EMS protocol, "Additional Orders" written in Section B may not be implemented by EMS personnel.

Reviewing POLST

It is recommended that POLST be reviewed periodically. Review is recommended when:

- The patient is transferred from one care setting or care level to another, or
- There is a substantial change in the patient's health status, or
- The patient's treatment preferences change.

Modifying and Voiding POLST

- A patient with capacity can, at any time, request alternative treatment or revoke a POLST by any means that indicates intent to revoke. It is recommended that revocation be documented by drawing a line through Sections A through D, writing "VOID" in large letters, and signing and dating this line.
- A legally recognized decisionmaker may request to modify the orders, in collaboration with the physician/NP/PA, based on the known desires of the patient or, if unknown, the patient's best interests.

This form is approved by the California Emergency Medical Services Authority in cooperation with the statewide POLST Task Force. For more information or a copy of the form, visit **www.caPOLST.org.**

SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Your doctor can provide you with a POLST form.

Or, click here to download the POLST. (Must be printed on pink paper.)

Five Wishes & POLST Form

POLST Form

- Stands for Physician's Orders for Life Sustaining Treatment
- Addresses emergency measures, not the same as an advance directive; compliments it
- Original MUST be in pink, black & white copies are acceptable
- Must be signed by a physician to be effective

Five Wishes & POLST Form

HOPE Hospice & Health Services

POLST Form

Section A, Cardiopulmonary Resuscitation:

- Attempt Resuscitation – CPR
- Do Not Attempt Resuscitation – DNR
- If CPR is chosen in Section A, then Full Treatment must be chosen in Section B

Five Wishes

POLST Form

Section B – Medical Interventions:

- Full Treatment – primary goal of prolonging life by all medically effective means
- Selective Treatment – goal of treating medical conditions while avoiding burdensome measures
- Comfort-Focused Treatment – primary goal of maximizing comfort

Five Wishes & POLST Form

POLST Form

Section C – Artificially Administered Nutrition:

- Long-term artificial nutrition, including feeding tubes
- Trial period of artificial nutrition, including feeding tubes
- No artificial means of nutrition, including feeding tubes

Five Wishes & POLST Form

POLST Form

Section D: Information & Signatures:

- Who the physician discussed the form with & if they don't have capacity, who is the legally recognized decisionmaker
- Is there an advance directive? Is it available for review? If so, who is the agent?
- Place for Physician's signature

Five Wishes & POLST Form

POLST Form

Section D, Information & Signatures:

- Signature of patient (person) OR their legally recognized decisionmaker
- Mailing address & phone number of the patient or their legally recognized decisionmaker

Five Wishes & POLST Form

POLST Form

Page Two (back side):

- Space for patient information
- Space to list an additional contact person in case the patient or their legally recognized decisionmaker is unavailable

Five Wishes & POLST Form

POLST Form

- The Form “follows” the person
- If in a private home, the form should be placed on the refrigerator or above the person’s bed
- If hospitalized or in a facility, make sure they have a copy of the POLST Form for their records (along with the advance directive such as the Five Wishes)
- A blank POLST Form can be obtained at your physician’s office

HOPE
Hospice & Health Services

Frequently Asked Questions

Five Wishes FAQ

Q: What is the relationship between Five Wishes and AgingWithDignity.org?

A: Aging With Dignity is a nationally-acclaimed non-profit with offices in Washington and Tallahassee, Florida.

Five Wishes is its publication.

Five Wishes FAQ

Q: What is the relationship between Hope Hospice and AgingWithDignity.org?

A: Hope Hospice has no affiliation or relationship besides spreading the word.

We believe this is a good, legal tool for any adult to express their healthcare wishes. We offer this presentation as a service to our communities.

Five Wishes FAQ

Q: Who should fill out Five Wishes?

A: Any adult (18 yo+) can.

If married, each person must fill out their own form. You cannot fill out one form for both of you. When completed, follow the instruction on Signing and Witnessing.

Five Wishes FAQ

Q: What if I already have a living will?

A: You can change to Five Wishes.
Follow instructions in booklet that says “How Do I Change To Five Wishes?” Then follow instructions on signing and witnessing.

When complete, you’ll have a new legal document. Next make sure to give your health agent a *copy* of your newly completed form. You will want to keep the original with yourself.

Five Wishes FAQ

Q: What if I don't live in a Five Wishes state?

A: Suggestion to fill out the state required form and then fill out the Five Wishes and attach it to the state form. Then make sure your health provider has both forms. Make sure that what you put in your Five Wishes form does not contradict what you wrote in your state form.

Wish #2 tracks with most Living Will forms.
Wish #1 tracks with most DPOA HC forms.

Five Wishes FAQ

Q: What if I live outside the United States?

A: Because most countries do not address advanced health care planning and the law, it will not be legal outside the US. However it is *still* a good way to express your preferences.

Most important is your family and h/c providers understand what is important to you if you get sick.

Five Wishes FAQ

Q: What if I move to a different state?

A: To determine if it is still valid, you need to look at the list of Five Wishes states. If your new state is a Five Wishes state, then no new form is needed.

If move to a non-Five Wishes state, then you must fill out the state's required form. Then you can attach the *old* Five Wishes form. This will tell your h/c provider your exact wishes.

Five Wishes FAQ

Q: Can I change my Five Wishes?

A: YES. You need to write “REVOKE” across the front of the old form and completely fill out the new one. Destroy the old copy. Tell your h/c agents that you have a new one and distribute. It’s strictly up to you if or when you want to update your form.

Five Wishes FAQ

Q: May I make copies of Five Wishes?

A: YES, only if copies of COMPLETED form.
They do not give permission to photo copy the blank form. It is copyrighted material.

Many hospitals, physicians, and other healthcare organizations prefer to see Five Wishes show up in the original booklet form, not as a photo copy.

Each person should fill out and sign one original form.

Five Wishes FAQ

Q: How do I start a conversation about Five Wishes?

A: What many people have found helpful is starting with your own wishes first. Begin by telling your loved ones what is important for you in case they have to make a decision on your behalf.

It also helps you become more familiar with the document so you can explain it to others.

Five Wishes FAQ

Q: Why three (3) options in Wish #2?

- Yes, I want life support treatment.
- No, I don't want life support treatment.
- I want it if my doctor thinks it could help.

A: You should pick the one that best reflects your wishes. Others have said "the third (middle ground) option describes in a few words exactly what I want to say." Choose the one that makes sense to you. Feel free to add other details on the blank lines on that wish.

Five Wishes FAQ

Q: Are there other Five Wishes resources?

A: YES.

"Next Steps" is a guide on discussing and coping with serious illness.

"My Wishes" is a form for children to express what's important to them if they get sick.

New *translations*: 20 languages and Braille

Final Five Wishes Thoughts

Congratulations on having the *courage* to fill out the Five Wishes document.

It can sometimes be tough to confront these questions. Once you've done it, you become increasingly at peace with making your wishes known. It is a gift to those who care about you because it let's them know what is important to you.

It's also a discussion tool to discuss with those you love most, so that you can be there for them.