# Medical Durable Power of Attorney for Healthcare Decisions

## I. Appointment of Agent and Alternates

I, _____,
Declarant, hereby appoint:

_____
*Name of Agent*

_____
*Agent's Best Contact Telephone Number*

_____
*Agent's email or alternative telephone number*

_____
*Agent's home address*

as my Agent to make and communicate my healthcare decisions when I cannot. This gives my Agent the power to consent to, or refuse, or stop any healthcare, treatment, service, or diagnostic procedure. My Agent also has the authority to talk with healthcare personnel, get information, and sign forms as necessary to carry out those decisions.

If the person named above is not available or is unable to continue as my Agent, then I appoint the following person(s) to serve in the order listed below.

_____
*Name of Alternate Agent #1*

_____
*Agent's Best Contact Telephone Number*

_____
*Agent's email or alternative telephone number*

_____
*Agent's home address*

_____
*Name of Alternate Agent #2*

_____
*Agent's Best Contact Telephone Number*

_____
*Agent's email or alternative telephone number*

_____
*Agent's home address*

## II. When Agent's Powers Begin

By this document, I intend to create a Medical Durable Power of Attorney which shall take effect either (initial one):

_____ (*Initials*) Immediately upon my signature.

_____ (*Initials*) When my physician or other qualified medical professional has determined that I am unable to make my or express my own decisions, and for as long as I am unable to make or express my own decisions.

## III. Instructions to Agent

My Agent shall make healthcare decisions as I direct below, or as I make known to him or her in some other way. If I have not expressed a choice about the decision or healthcare in question, my Agent shall base his or her decisions on what he or she, in consultation with my healthcare providers, determines is in my best interest. I also request that my Agent, to the extent possible, consult me on the decisions and make every effort to enable my understanding and find out my preferences.

*State here any desires concerning life-sustaining procedures, treatment, general care and services, including any special provisions or limitations:*

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

My signature below indicates that I understand the purpose and effect of this document:

_____
*Signature of Declarant* *Date*

# Addendum to Medical Durable Power of Attorney — *recommended, not required*

## 1. Signature of the Appointed Agent

Although not required by Colorado law, my signature below indicates that I have been informed of my appointment as a Healthcare Agent under Medical Durable Power of Attorney for (name of Declarant)

_____ .

I am at least eighteen (18) years old. I accept the responsibilities of that appointment, and I have discussed with the Declarant his or her wishes and preferences for medical care in the event that he or she cannot speak for him- or herself.

I understand that I am always to act in accordance with his or her wishes, not my own, and that I have full authority to speak with his or her healthcare providers, examine healthcare records, and sign documents in order to carry out those wishes. I also understand that my authority as a Healthcare Agent is only in effect when the Declarant is unable to make his or her own decisions and that it automatically expires at his or her death.

If I am an alternate Agent, I understand that my responsibilities and powers will only take effect if the primary Agent is unable or unwilling to serve.

_____
*Primary Agent's Signature*

_____
*Printed Name*

_____
*Date*

_____
*Alternate Agent #1 Signature*

_____
*Printed Name*

_____
*Date*

_____
*Alternate Agent #2 Signature*

_____
*Printed Name*

_____
*Date*

## 2. Signature of Witnesses and Notary

The signature of two witnesses and a notary are not required by Colorado law for proper execution of a Medical Durable Power of Attorney; however, they may make the document more acceptable in other states.

This document was signed by (*name of Declarant*)

_____

in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We are at least eighteen (18) years old.

_____
*Signature of Witness*

_____
*Printed Name*

_____
*Address*

_____

_____
*Signature of Witness*

_____
*Printed Name*

_____
*Address*

_____

### Notary (optional)

State of _____
County of _____
SUBSCRIBED and sworn to before me by
_____, the Declarant,
and _____
and _____
witnesses, as the voluntary act and deed of the Declarant this
day of _____, 20____.

_____
Notary Public
My commission expires: _____

# Advance Directive for Surgical / Medical Treatment (Living Will)

*On completion, give copies to your physician, family members, and Healthcare Agent.*
*If you wish to revoke or replace this document, mark it clearly as "Revoked" or destroy it and all its copies, if possible.*
*If you do not understand the choices and options, seek advice from a healthcare provider or other qualified advisor.*

## I. DECLARATION

I, _____,
am at least eighteen (18) years old and able to make and communicate my own decisions. It is my direction that the following instructions be followed if I am diagnosed by two qualified doctors to be in a terminal condition or Persistent Vegetative State.

**A. Terminal Condition** If at any time my physician and one other qualified physician certify in writing that I have a terminal condition, and I am unable to make or communicate my own decisions about medical treatment, then:

### 1. Life-Sustaining Procedures (*initial one*)

_____ (*Initials*) I direct that all life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____ (*Initials*) I direct that life-sustaining procedures shall be continued for/until (state timeframe or goal):

_____

### 2. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

_____ (*Initials*) Artificial nutrition and hydration shall not be continued.

_____ (*Initials*) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

_____

_____ (Initials) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

**B. Persistent Vegetative State** If at any time my physician and one other qualified physician certify in writing that I am in a Persistent Vegetative State, then:

### 1. Life-Sustaining Procedures (*initial one*)

_____ (*Initials*) I direct that life-sustaining procedures shall be withdrawn and/or withheld, not including any procedure considered necessary by my healthcare providers to provide comfort or relieve pain.

_____ (*Initials*) I direct that life-sustaining procedures shall be continued for/until (state timeframe or goal):

_____

### 2. Artificial Nutrition and Hydration

If I am receiving nutrition and hydration by tube, I direct that one of the following actions be taken (initial one):

_____ (*Initials*) Artificial nutrition and hydration shall not be continued.

_____ (*Initials*) Artificial nutrition and hydration shall be continued for/until (state timeframe or goal):

_____

_____ (*Initials*) Artificial nutrition and hydration shall be continued, if medically possible and advisable according to my healthcare providers.

## II. OTHER DIRECTIONS

Please indicate below if you have attached to this form any other instructions for your care after you are certified in a terminal condition or Persistent Vegetative State (for instance, to be enrolled in a hospice program, remain at or be transferred to home, discontinue or refuse other treatments such as dialysis, transfusions, antibiotics, diagnostic tests, etc.) *(initial one)*:

_____ (*Initials*) Yes, I have attached other directions.

_____ (*Initials*) No, I do not have any other directions.

## III. RESOLUTION WITH MEDICAL POWER OF ATTORNEY (*initial one*)

_____ (*Initials*) My Agent under my Medical Durable Power of Attorney shall have the authority to override any of the directions stated here, whether I signed this declaration before or after I appointed that Agent.

_____ (*Initials*) My directions as stated here may not be overridden or revoked by my Agent under Medical Durable Power of Attorney, whether I signed this declaration before or after I appointed that Agent.

## Advance Directive for Surgical / Medical Treatment (Living Will) (continued)

### IV. CONSULTATION WITH OTHER PERSONS

I authorize my healthcare providers to discuss my condition and care with the following persons, understanding that these persons are not empowered to make any decisions regarding my care, unless I have appointed them as my Healthcare Agents under Medical Durable Power of Attorney.

*Name* *Relationship*

_____

_____

_____

_____

_____

### V. NOTIFICATION OF OTHER PERSONS

Before withholding or withdrawing life-sustaining procedures, my healthcare providers shall make a reasonable effort to notify the following persons that I am in a terminal condition or Persistent Vegetative State. My healthcare providers have my permission to discuss my condition with these persons. I do NOT authorize these persons to make medical decisions on my behalf, unless I have appointed one or more of them as my Agent(s) under Medical Durable Power of Attorney.

*Name* *Telephone number or email*

_____

_____

_____

_____

_____

### VI. ANATOMICAL GIFTS

_____ (*Initials*) I wish to donate my (check one or both)
☐ organs and/or ☐ tissues, if medically possible.

_____ (*Initials*) I do not wish donate my organs or tissues.

### VII. SIGNATURE

I execute this declaration, as my free and voluntary act, this day of _____, 20____.

_____

*Declarant signature*

### VIII. DECLARATION OF WITNESSES

This declaration was signed by (*name of Declarant*)

_____

in our presence, and we, in the presence of each other, and at the Declarant's request, have signed our names below as witnesses. We did not sign the Declarant's signature. We are not doctors or employees of the attending doctor or healthcare facility in which the Declarant is a patient. We are neither creditors nor heirs of the Declarant and have no claim against any portion of the Declarant's estate at the time this declaration was signed. We are at least eighteen (18) years old and under no pressure, undue influence, or otherwise disqualifying disability.

_____

*Signature of Witness*

_____

*Printed Name*

_____

*Address*

_____

_____

*Signature of Witness*

_____

*Printed Name*

_____

*Address*

_____

### Notary (optional)

State of _____
County of _____
SUBSCRIBED and sworn to before me by
_____, the Declarant,
and _____
and _____
witnesses, as the voluntary act and deed of the Declarant this day of _____, 20____.

_____

Notary Public
My commission expires: _____

# Patient's or Authorized Agent's Directive to Withhold Cardio-Pulmonary Resuscitation (CPR)

This template is consistent with rules adopted by the Colorado State Board of Health at 6 CCR 1015-2

## Patient's Information

Patient's Name _____
(Printed Name)

*If Applicable* Name of Agent/Legally Authorized Guardian/Parent of Minor Child _____
(Printed Name)

Date of Birth ____/____/_____ Gender ☐ Male ☐ Female ☐ Eye Color _____ ☐ Hair Color _____

Race Ethnicity ☐ Asian or Pacific Islander ☐ Black, non-Hispanic ☐ White, non-Hispanic
☐ American Indian or Alaska Native ☐ Hispanic ☐ Other

If Applicable- Name of hospice program/provider _____

## Physician's Information

Physician's Name _____
(Printed Name)

Physician's Address _____

Physician's telephone (  ) _____ Physician's Colorado License # _____

## Directive Attestation

Check **ONLY** the information that applies:

☐ Patient I am over the age of 18 years, of sound mind and acting voluntarily. It is my desire to initiate this directive on my behalf. I have been advised that as a result of this directive, if my heart or breathing stops or malfunctions, I will not receive CPR and I may die.

☐ Authorized Agent/Legally Authorized Guardian/Parent of Minor Child I am over the age of 18 years, of sound mind, and I am legally authorized to act on behalf of the patient named above in the issuance of this directive. I have been advised that as a result of this directive, if the patient's heart or breathing stops or malfunctions, the patient will not receive CPR and may die.

☐ Tissue Donation I hereby make an anatomical gift, to be effective upon my death of:
☐ Any needed tissues
The following tissues ☐ Skin ☐ Cornea ☐ Bone, related tissues and tendons

**I hereby direct emergency medical services personnel, health care providers, and any other person to withhold cardio-pulmonary resuscitation in the event that my/the patient's heart or breathing stops or malfunctions. I understand that this directive does not constitute refusal of other medical interventions for my/the patient's care and comfort. If I/the patient am/is admitted to a healthcare facility, this directive shall be implemented as a physician's order, pending further physician's orders.**

_____ _____
☐ Signature of Patient
☐ Authorized Agent/Legally Authorized Guardian/Parent of Minor Child
Physician Signature

_____ _____
Date Date