Wyoming Advance Healthcare Directive Form

You have the right to give instructions about your own healthcare. You also have the right to name someone else to make healthcare decisions for you. This form lets you do either or both of these things.

If you use this form, you may choose whether to complete all or any part of it or you may modify all or any part of it. You also are free to use a different form, but please note that certain provisions must be included in the form for it to be a legal document in Wyoming.

Part 1

The first section of this form is a power of attorney for healthcare. This lets you name another individual as agent to make healthcare decisions for you if you become incapable of making your own decisions or if you want someone else to make those decisions for you now even though you are still capable.

You also may name an alternate agent to act for you if your first choice is not willing, able or reasonably available to make decisions for you. Unless related to you, your agent may not be an owner, operator or employee of a residential or community care facility at which you are receiving care.

Unless the form you sign limits the authority of your agent, your agent may make all healthcare decisions for you. This form has a place for you to limit the authority of your agent. You need not limit the authority of your agent if you wish to rely on your agent for all healthcare decisions that may have to be made. If you choose not to limit the authority of your agent, your agent will have the right to:

a) Consent or refuse consent to any care, treatment, service or procedure to maintain, diagnose or otherwise affect a physical or mental condition;

b) Select or discharge healthcare providers and institutions;

c) Approve or disapprove diagnostic tests, surgical procedures, medication and orders not to resuscitate;

d) Direct the provision, withholding or withdrawal of artifical nutrition and hydration and all other forms of healthcare.

Part 2

The second section of this form lets you give specific instruction about any aspect of your healthcare. Choices are provided for you to express your wishes regarding the provision, withholding or withdrawal of treatment to keep you alive, including the provision of artificial nutrition and hydration, as well as the provision of pain relief. Space is also provided for you to add to the choices you have made or for you to write out any additional wishes.

After completing this form, sign and date the form at the end. This form must either be signed before a notary public or, in the alternative be witnessed by two (2) witness.

Give a copy of the signed and completed form to your physician, to any other healthcare providers you may have, to any healthcare institution at which you are receiving care and to any healthcare agents you have named. You should talk to the person you have named as agent to make sure that he or she understands your wishes and is willing to take the responsibility.

You have the right to revoke this advance healthcare directive or replace this form at any time.

CAMPBELL COUNTY MEMORIAL HOSPITAL

Wyoming Health Care Directive
POWER OF ATTORNEY FOR HEALTH CARE

I, _____, designate the following individual as my agent to make health care decisions for me:

_____
Name of individual you choose as agent

_____
Address City State Zip Code

_____
Home Phone Work Phone Mobile Phone

OPTIONAL: If my agent is not willing, not able or is not reasonably available to make a health care decision for me, I designate as my alternate agent:

_____
Name of individual you choose as agent

_____
Address City State Zip Code

_____
Home Phone Work Phone Mobile Phone

AGENT'S AUTHORITY:
My agent is authorized to make all health care decisions for me, including decisions to provide, withhold or withdraw artifical nutrition and hydration and all other forms of health care to keep me alive, except as I state:

_____

_____

_____

_____

_____

_____

_____

_____

My agent's authority becomes effective when my supervising health care provider determines that I lack the capacity to make my own health care decisions unless I initial the following statement:

_____ **My agent's authority to make health care decisions for me takes effect *immediately.***

AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this Power of Attorney for Health Care, any instructions I provide on this form, and my other wishes to the extent known to my agent.

Wyoming Health Care Directive
INSTRUCTIONS FOR HEALTH CARE

END OF LIFE DECISIONS

Please strike through and initial any wording that you do NOT want.

I, _____, direct my health care providers and other involved in my care to withhold or withdraw treatment in accordance with the choice I have identified below with my initials:

_____ **Choice to Prolong Life:** I want my life prolonged as long as possible within the limits of generally accepted health care standards.

OR

_____ **Choice Not to Prolong Life:** I do not want my life prolonged if:

I have an incurable and irreversible condition that will result in my death within a relatively short time,

I become unconscious and, to a reasonable degree of medical certainty, I will not regain consciousness, or

The likely risks and burdens of treatment would outweigh the expected benefits.

ARTIFICIAL NUTRITION AND HYDRATION

Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made as designated above unless I initial the following.

_____ If I initial this line, artificial nutrition must be provided regardless of my condition and regardless of the choice I have made under **END OF LIFE DECISIONS** above.

_____ If I initial this line, artifical hydration must be provided regardless of my condition and regardless of the choice I have made under **END OF LIFE DECISIONS** above.

RELIEF FROM PAIN

Except as I state in the following space, I direct that treatment for alleviation of pain or discomfort be provided at all times:

_____

_____

SIGNATURES: Sign and date this form:

_____
Print Name of Principal

_____
Signature of Principal Date

_____
Address City State Zip Code

SIGNATURE OF WITNESSES OR NOTARY PUBLIC
This document must be either notarized or witnessed by two individuals.

I declare under penalty of perjury under the laws of Wyoming that the person who signed and acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this document in my presence, that the principal appears to be of sound mind. I am not the person appointed agent by this document, I am not related to the principal by blood or marriage, I am not the treating health care provider, an employee of the treating health care provider, the operator of a community care or residential care facility, or directly financially responsible for the principal's medical care.

_____
Print Name of Witness

_____
Signature of Witness Date

_____
Print Name of Witness

_____
Signature of Witness Date

NOTARY
Subscribed and sworn to and acknowledged before me by _____

the Principal, this _____ day of _____, _____.
My commission expires:

_____
Notary Public