TELL ME WHAT YOU WANT

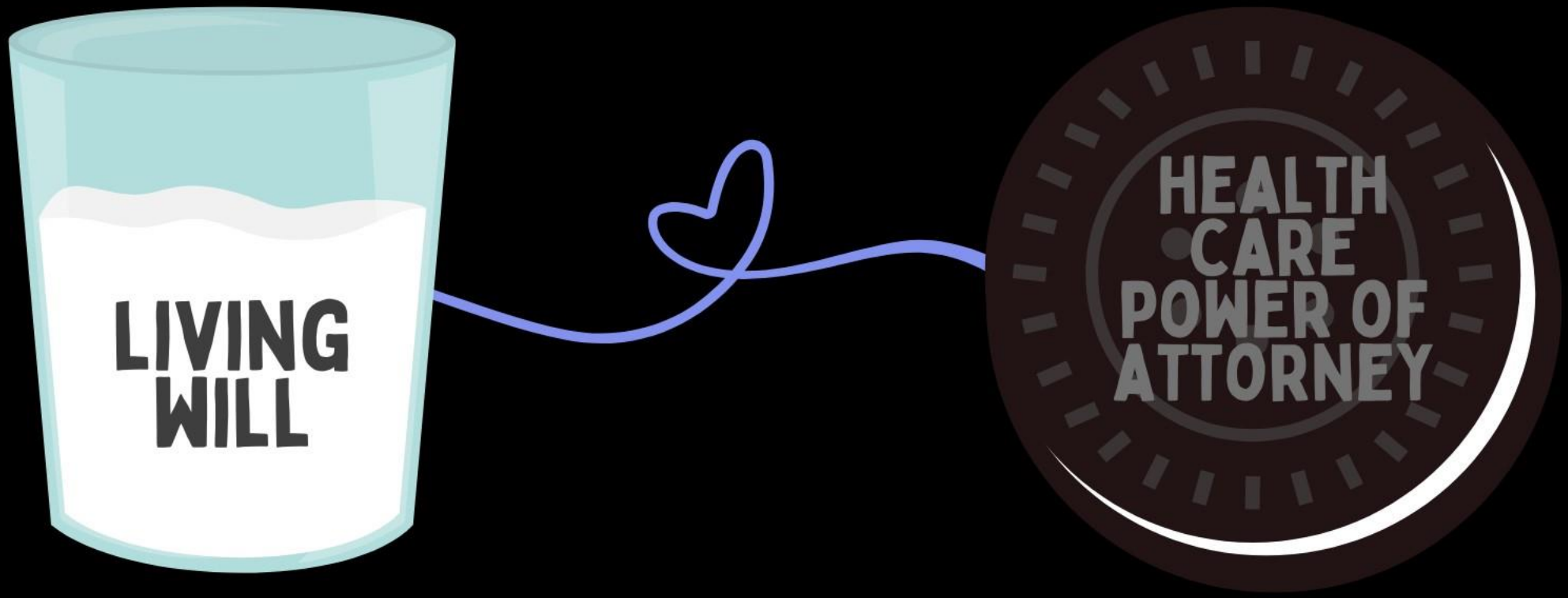
WHAT YOU REALLY, REALLY WANT

ADVANCE DIRECTIVES IN THE ED

AMY RAMSAY, MD, FACEP

APRIL 23, 2024

ADVANCE DIRECTIVES



ADVANCE DIRECTIVES

LIVING WILL

+

HEALTH CARE POWER OF ATTORNEY

ADVANCE DIRECTIVES

LIVING WILL

ALLOWS YOU TO EXPRESS YOUR CHOICES IN WRITING ABOUT YOUR CARE ONLY IF YOU ARE **TERMINALLY ILL** OR **PERMANENTLY UNCONSCIOUS**

ADVANCE DIRECTIVES

HEALTH CARE POWER OF ATTORNEY

YOU CHOOSE A PERSON TO MAKE HEALTH CARE DECISIONS FOR YOU WHILE YOU CANNOT MAKE THEM YOURSELF

ADVANCE DIRECTIVES

STATE OF SOUTH CAROLINA)
)
COUNTY OF _____)

DECLARATION OF A DESIRE FOR A NATURAL DEATH

I, _____, Declarant, being at least eighteen years of age and a resident of and domiciled in the City of _____, County of _____, State of South Carolina, make this Declaration this _____ day of _____, 20_____.

I willfully and voluntarily make known my desire that no life-sustaining procedures be used to prolong my dying if my condition is terminal or if I am in a state of permanent unconsciousness, and I declare: If at any time I have a condition certified to be a terminal condition by two physicians who have personally examined me, one of whom is my attending physician, and the physicians have determined that my death could occur within a reasonably short period of time without the use of life-sustaining procedures or if the physicians certify that I am in a state of permanent unconsciousness and where the application of life-sustaining procedures would serve only to prolong the dying process, I direct that the procedures be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure necessary to provide me with comfort care.

INSTRUCTIONS CONCERNING ARTIFICIAL NUTRITION AND HYDRATION

INITIAL ONE OF THE FOLLOWING STATEMENTS

1. If my condition is terminal and could result in death within a reasonably short time,

A._____I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

B._____I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

The following line is not part of the standard South Carolina form. It has been added at the request of many people as a point of clarification. If you do want it to apply, please initial the line below:

C._____Nevertheless, I do want treatment to ensure my comfort and to relieve pain and suffering and minimal intravenous fluids to avoid discomfort.

INITIAL ONE OF THE FOLLOWING STATEMENTS

2. If I am in a persistent vegetative state or other condition of permanent unconsciousness,

A._____I direct that nutrition and hydration BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

B._____I direct that nutrition and hydration NOT BE PROVIDED through any medically indicated means, including medically or surgically implanted tubes.

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_____ Nevertheless, I do want treatment to ensure my comfort and to relieve pain and suffering and minimal intravenous fluids to avoid discomfort.

3. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this Declaration be honored by my family and physicians and any health facility in which I may be a patient as the final expression of my legal right to refuse medical or surgical treatment, and I accept the consequences from the refusal.

4. I am aware that this Declaration authorizes a physician to withhold or withdraw life-sustaining procedures. I am emotionally and mentally competent to make this Declaration.

APPOINTMENT OF AN AGENT (OPTIONAL)

1. You may give another person authority to revoke this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.
Name of Agent with Power to Revoke: _____
Address:_____
Telephone Number:_____

2. You may give another person authority to enforce this declaration on your behalf. If you wish to do so, please enter that person's name in the space below.
Name of Agent with Power to Enforce: _____
Address: _____
Telephone Number: _____

REVOCATION PROCEDURES

THIS DECLARATION MAY BE REVOKED BY ANY ONE OF THE FOLLOWING METHODS. HOWEVER, A REVOCATION IS NOT EFFECTIVE UNTIL IT IS COMMUNICATED TO THE ATTENDING PHYSICIAN.

(1) BY BEING DEFACED, TORN, OBLITERATED, OR OTHERWISE DESTROYED, IN EXPRESSION OF YOUR INTENT TO REVOKE, BY YOU OR BY SOME PERSON IN YOUR PRESENCE AND BY YOUR DIRECTION. REVOCATION BY DESTRUCTION OF ONE OR MORE OF MULTIPLE ORIGINAL DECLARATIONS REVOKES ALL OF THE ORIGINAL DECLARATIONS;

(2) BY A WRITTEN REVOCATION SIGNED AND DATED BY YOU EXPRESSING YOUR INTENT TO REVOKE;

STATE OF SOUTH CAROLINA)
)
COUNTY OF _____)

DURABLE POWER OF ATTORNEY FOR HEALTH CARE FOR

_____, **Name**

1. DESIGNATION OF HEALTH CARE AGENT.

I, _____, hereby appoint:

Name: _____
Address: _____
_____
Home Telephone: _____
Work Telephone: _____
Cell Telephone: _____

as my Agent to make health care decisions for me as authorized in this document.

Successor Agent: If an agent named by me dies, becomes legally disabled, resigns, refuses to act, becomes unavailable, or if an agent who is my spouse is divorced or separated from me, I name the following as successors to my agent, each to act alone and successively, in the order named:

a. First Alternate Agent:

Name: _____
Address: _____
Telephone: Home:_____ ; Work: _____; Cell:_____

b. Second Alternate Agent:

Name: _____
Address: _____
Telephone: Home: _____; Work: _____; Cell:_____

Unavailability of Agent(s): If at any relevant time the agent or successor agents named here are unable or unwilling to make decisions concerning my health care, and those decisions are to be made by a guardian, by the Probate Court, or by a surrogate pursuant to the Adult Health Care Consent Act, it is my intention that the guardian, Probate Court, or surrogate make those decisions in accordance with my directions as stated in this document.

2. EFFECTIVE DATE AND DURABILITY.

By this document I intend to create a durable power of attorney effective upon, and only during, any period of mental incompetence, except as provided in Paragraph 3 below.

3. HIPAA AUTHORIZATION.

When considering or making health care decisions for me, all individually identifiable health information and medical records shall be released without restriction to my health care agent(s) and/or my alternate health care agent(s) named above including, but not limited to, (i) diagnostic, treatment, other health care, and related insurance and financial records and information associated with any past, present, or future physical or mental health condition including, but not limited to, diagnosis or treatment of HIV/AIDS, sexually transmitted disease(s), mental illness, and/or drug or alcohol abuse and (ii) any written opinion relating to my health that such health care agent(s) and/or alternative health care agent(s) may have requested. Without limiting the generality of the foregoing, this release authority applies to all health information and medical records governed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 USC 1320(d) and 45 CFR 160-164; is effective whether or not I am mentally competent; has no expiration date; and shall terminate only in the event that I revoke the authority in writing and deliver it to my health care provider.

4. AGENT'S POWER

I grant to my agent full authority to make decisions for me regarding my health care. In exercising this authority, my agent shall follow my desires as stated in this document or otherwise expressed by me or known to my agent. In making any decision, my agent shall attempt to discuss the proposed decision with me to determine my desires if I am able to communicate in any way. If my agent cannot determine the choice I would want made, then my agent shall make a choice for me based upon what my agent believes to be in my best interests. My agent's authority to interpret my desires is intended to be as broad as possible, except for any limitations I may state below.

Accordingly, unless specifically limited by the provisions specified below, my agent is authorized as follows:

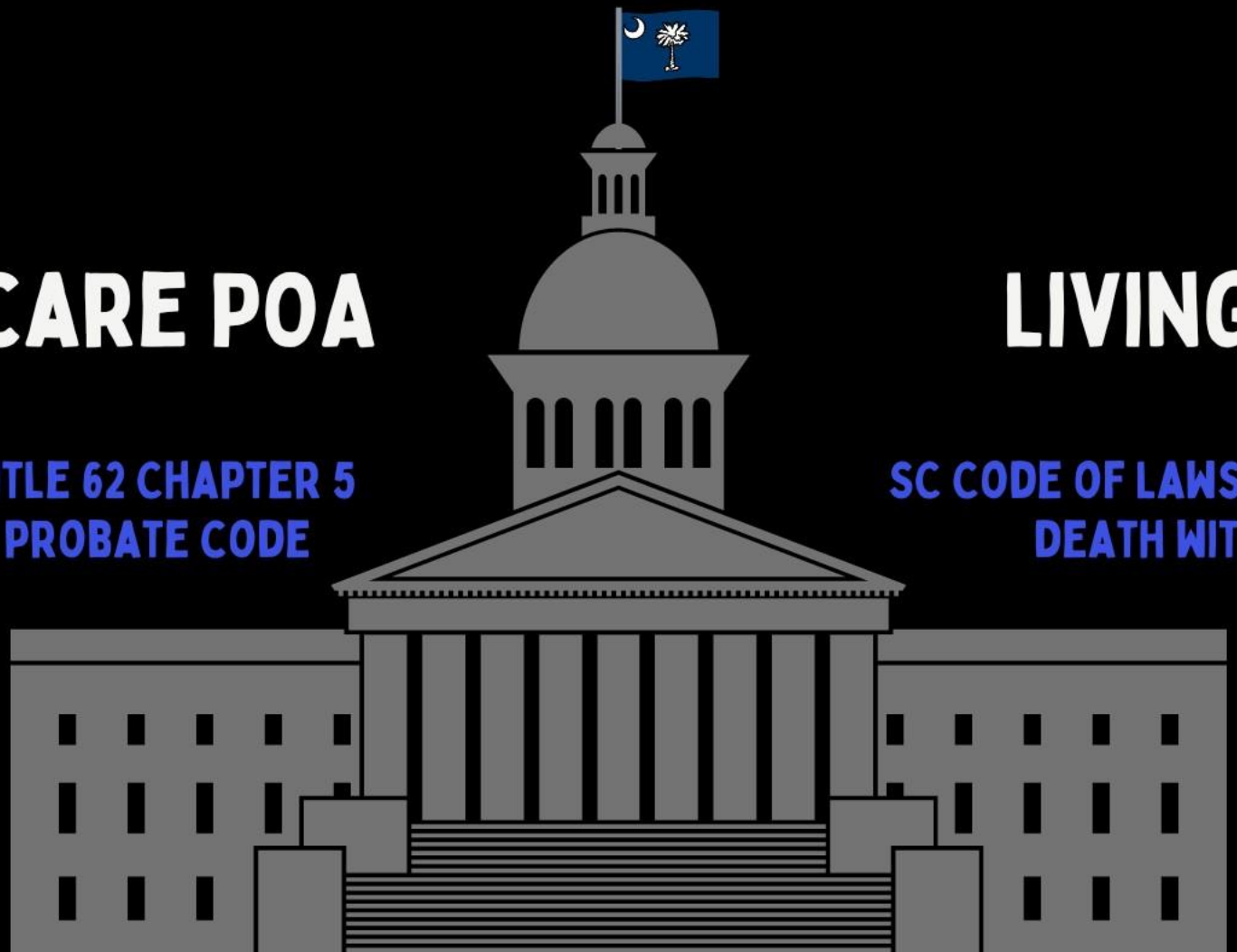
A. To consent, refuse, or withdraw consent to any and all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including, but not limited to, artificial respiration, nutritional support and hydration, and cardiopulmonary resuscitation.

B. To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of, but not intentionally cause, my death.

C. To authorize my admission to or discharge, even against medical advice, from any hospital, nursing care facility, or similar facility or service.

D. To take another action necessary to making, documenting, and assuring implementation of decisions concerning my health care, including, but not limited to, granting any waiver or release from liability required by any hospital, physician, nursing care provider, or other health care provider; signing any documents relating to refusals of treatment or the leaving of a facility

THESE ARE NOT SUGGESTIONS
THIS IS THE LAW IN SOUTH CAROLINA



HEALTH CARE POA

SC CODE OF LAWS TITLE 62 CHAPTER 5
SOUTH CAROLINA PROBATE CODE

LIVING WILL

SC CODE OF LAWS TITLE 44 CHAPTER 77
DEATH WITH DIGNITY ACT

DHEC

Emergency Medical Services
Do Not Resuscitate Order

SOUTH CAROLINA
EMERGENCY MEDICAL SERVICES

RESUSCITATE

DO NOT RESUSCITATE ORDER

NOTICE TO EMS PERSONNEL

This notice is to inform all emergency medical personnel who may be called to render assistance to

_____ that he/she has a terminal condition which has been diagnosed by me and has
(Name of Patient)

specifically requested that no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardiopulmonary arrest.

REVOCATION PROCEDURE

THIS FORM MAY BE REVOKED BY AN ORAL STATEMENT BY THE PATIENT TO EMS PERSONNEL, OR BY MULTILATING, OBLITERATING, OR DESTROYING THE DOCUMENT IN ANY MANNER.

Date | Patient's Signature (or Surrogate or Agent)

Physician's Name (Please Print) | Physician's Signature

Physician's Address | Physician's Telephone Number

DHEC 3462 (12/2000) **SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL**

FIVE WISHES®

MY WISH FOR:

1. The Person I Want to Make Care Decisions for Me When I Can't
2. The Kind of Medical Treatment I Want or Don't Want
3. How Comfortable I Want to Be
4. How I Want People to Treat Me
5. What I Want My Loved Ones to Know

Print Your Name

Birthdate

dhec

South Carolina
Physician Orders for Scope of Treatment (POST)

Patient's Diagnosis:

Patient Last Name: | Patient First Name/MI:

Patient Date of Birth: (MM/DD/YYYY) | Patient/Legal Representative Phone Number:

Social Security Number last 4 digits: (Optional) XXX-XX- | Gender: ☐M ☐F ☐Other

Patient Mailing Address: (street/city/state/zip)

Section A (Check One Box Only) — **CARDIOPULMONARY RESUSCITATION (CPR): Unresponsive, pulseless, & not breathing.**

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

If patient is not in cardiopulmonary arrest, follow orders in B, C and D.

Section B (Check One Box Only) — **MEDICAL INTERVENTIONS: If patient has pulse and/or is breathing.**

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*
Treatment Plan: **All treatments including breathing machine.**

☐ **Limited Treatment.** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airways interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Avoid ICU if possible.*
Treatment Plan: **Provide basic medical treatments.**

☐ **Comfort Measures Only.** Keep clean, warm and dry. Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. *Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.*
Treatment Plan: **Provide treatments for comfort through symptom management.**

Additional Orders:

Section C (Check One Box Only) — **ANTIBIOTICS**

☐ Use antibiotics if life can be prolonged.
☐ Determine use or limitation of antibiotics when infection occurs.
☐ No antibiotics except for relief of pain and discomfort.

Additional Orders:

Section D (Check One Box in Each Column) — **ARTIFICIALLY ADMINISTERED NUTRITION AND FLUIDS: Offer food and fluids by mouth if feasible.**

☐ Long-term artificial nutrition by tube.	☐ Long-term IV fluids.
☐ Trial period of artificial nutrition by tube.	☐ Trial period of IV fluids.
☐ Do not insert feeding tube.	☐ No IV fluids.
☐ Decide when/if the situation arises.	☐ Decide when/if the situation arises.
Additional Orders:	Additional Orders:

Section E — Signature of Physician, APRN, or PA

Signature of Physician, Advanced Practice Registered Nurse, or Physician Assistant
My signature below indicates to the best of my knowledge that the patient has been diagnosed with a serious illness or, based upon a medical diagnosis, may be expected to lose capacity within 12 months, and that these orders are consistent with the patient's medical condition, diagnosis, and preferences.

Physician/APRN/PA Signature: *(required)* | Physician/APRN/PA Name: *(print)* | ☐Physician ☐APRN ☐PA *(Select one)*

Date: (MM/DD/YYYY) *(required)* | Physician/APRN/PA Phone Number: | Physician/APRN/PA License #:

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Legal Representative ☐ Other:

Section F — Signature of Patient or Legal Representative

Signature of Patient or Legal Representative
I am aware that this form is voluntary. I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician, physician assistant, or advanced practice registered nurse and this document reflects those treatment preferences. *If signed by a legal representative, preferences expressed must reflect patient's wishes as best understood by the legal representative.*

Signature: *(required)* | Relationship: *(write "self" if patient)*

Print Name: | Date: (MM/DD/YYYY) *(required)* | Phone Number:

Section G — Facilitator (if applicable)

Facilitator Assisting with POST Form Completion (if applicable)

Print Name: | Date: (MM/DD/YYYY) | Phone Number:

FORM MUST ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DHEC 4061 (02/2020) **SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL**

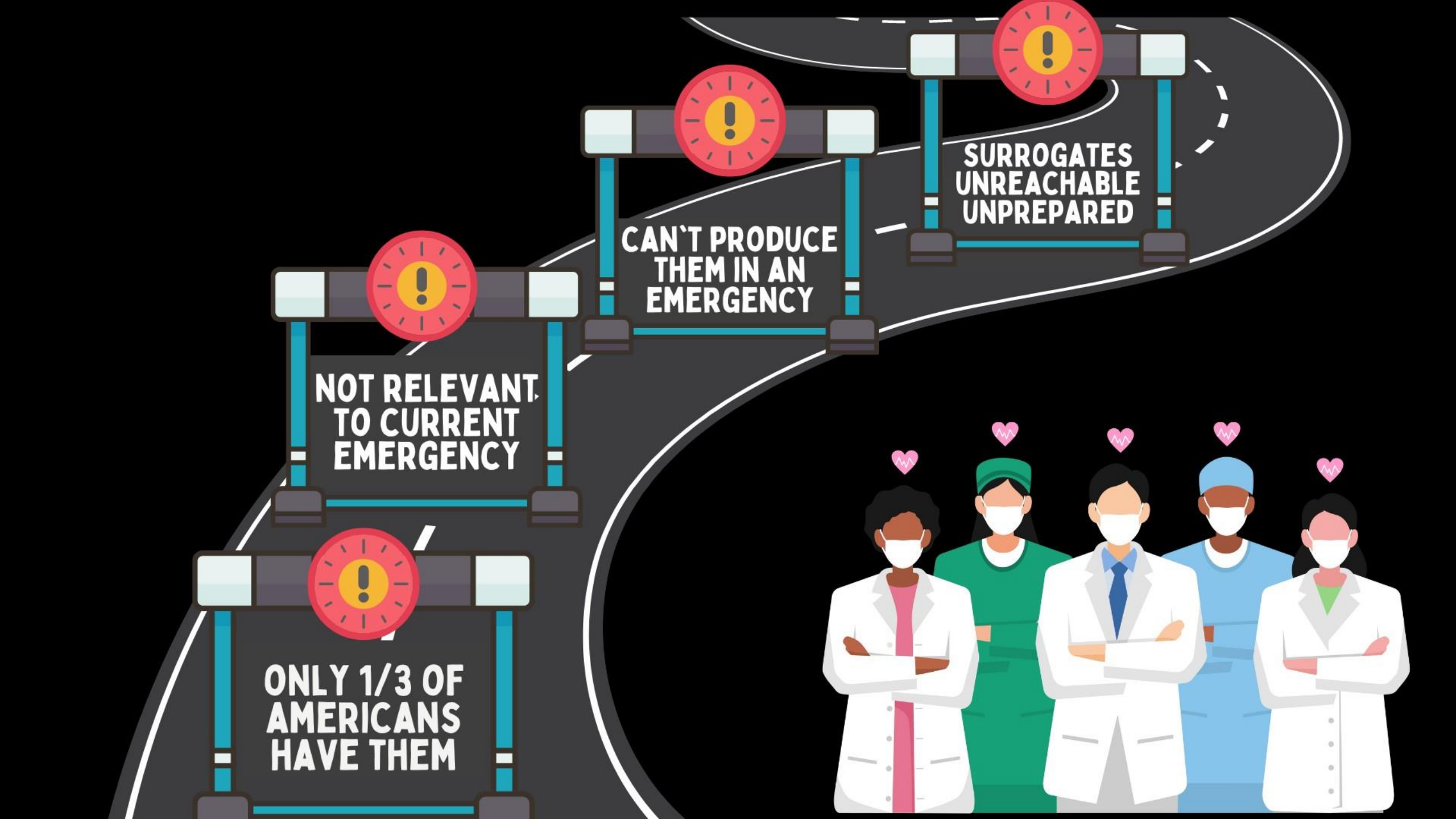
EMS CAN HONOR

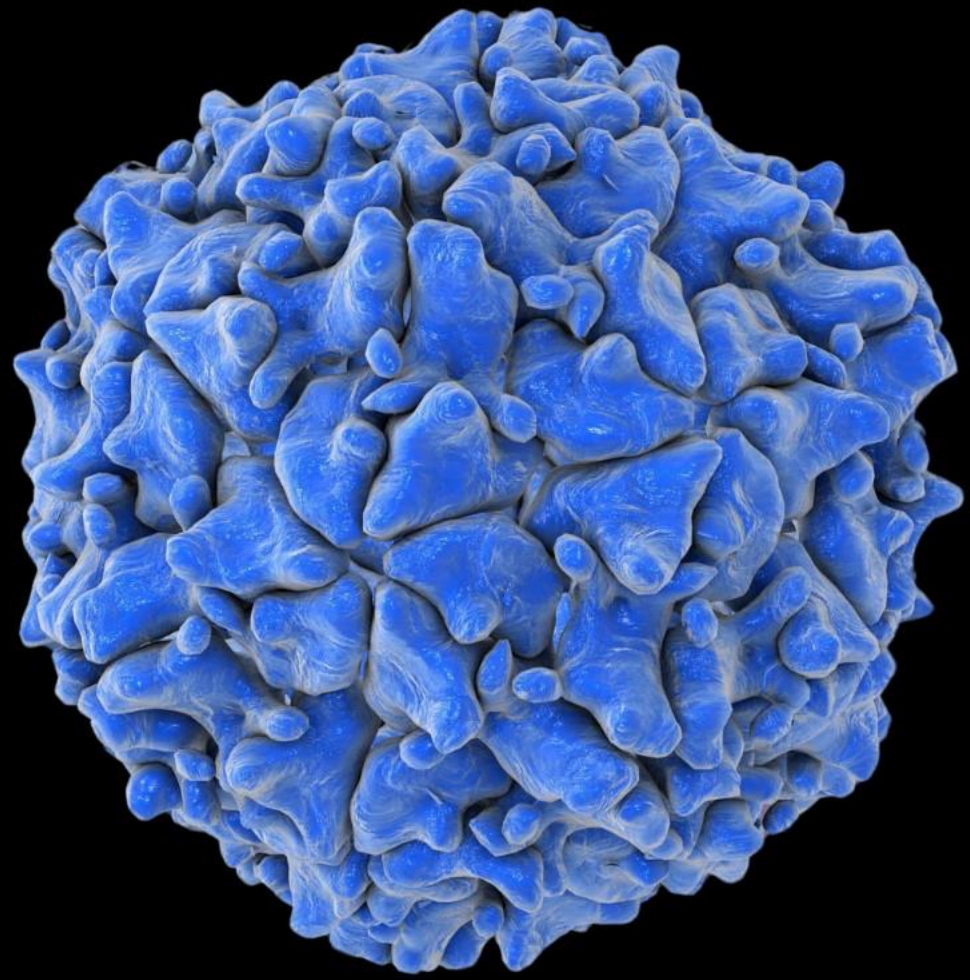
- ✓ SC POST FORM
- ✓ SC DNR FORM
- ✓ SC DNR BRACELET
- ✗ LIVING WILL

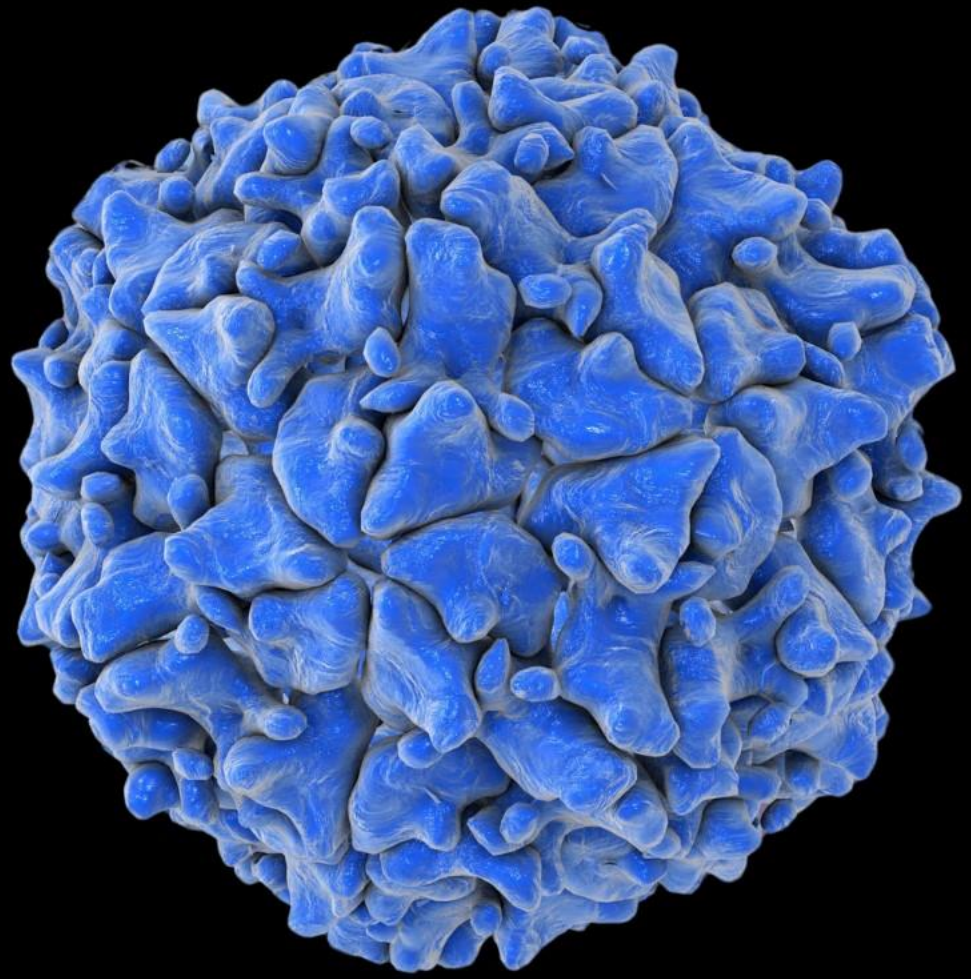
ORDER OF SURROGATE DECISION MAKERS

THE ADULT HEALTH CARE CONSENT ACT

1. SPOUSE
2. ADULT CHILD
3. PARENT
4. ADULT SIBLING
5. GRANDPARENT
6. CLOSE RELATIVE
7. FRIEND


SURROGATES UNREACHABLE UNPREPARED
CAN`T PRODUCE THEM IN AN EMERGENCY
NOT RELEVANT TO CURRENT EMERGENCY
ONLY 1/3 OF AMERICANS HAVE THEM



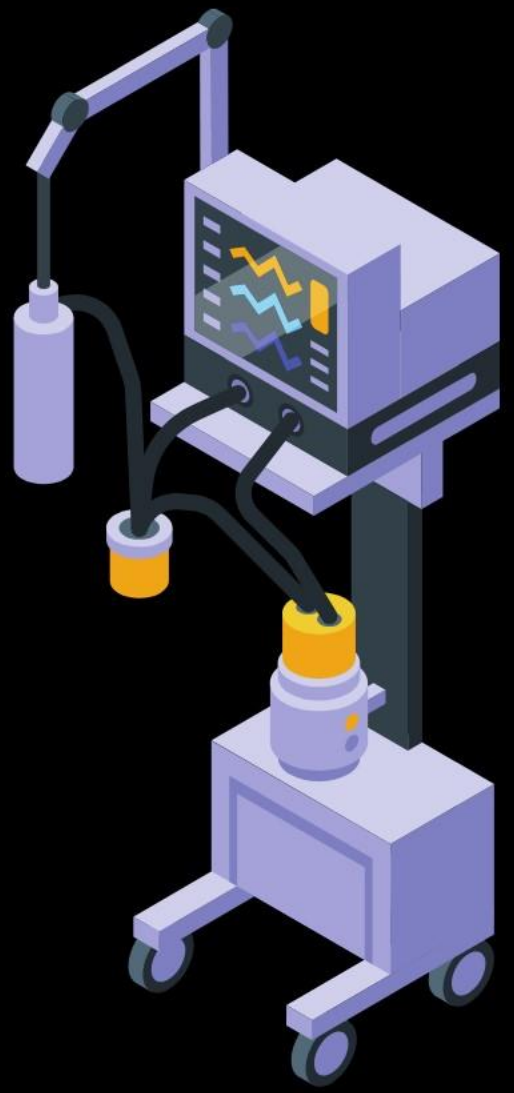


POLIO VIRUS

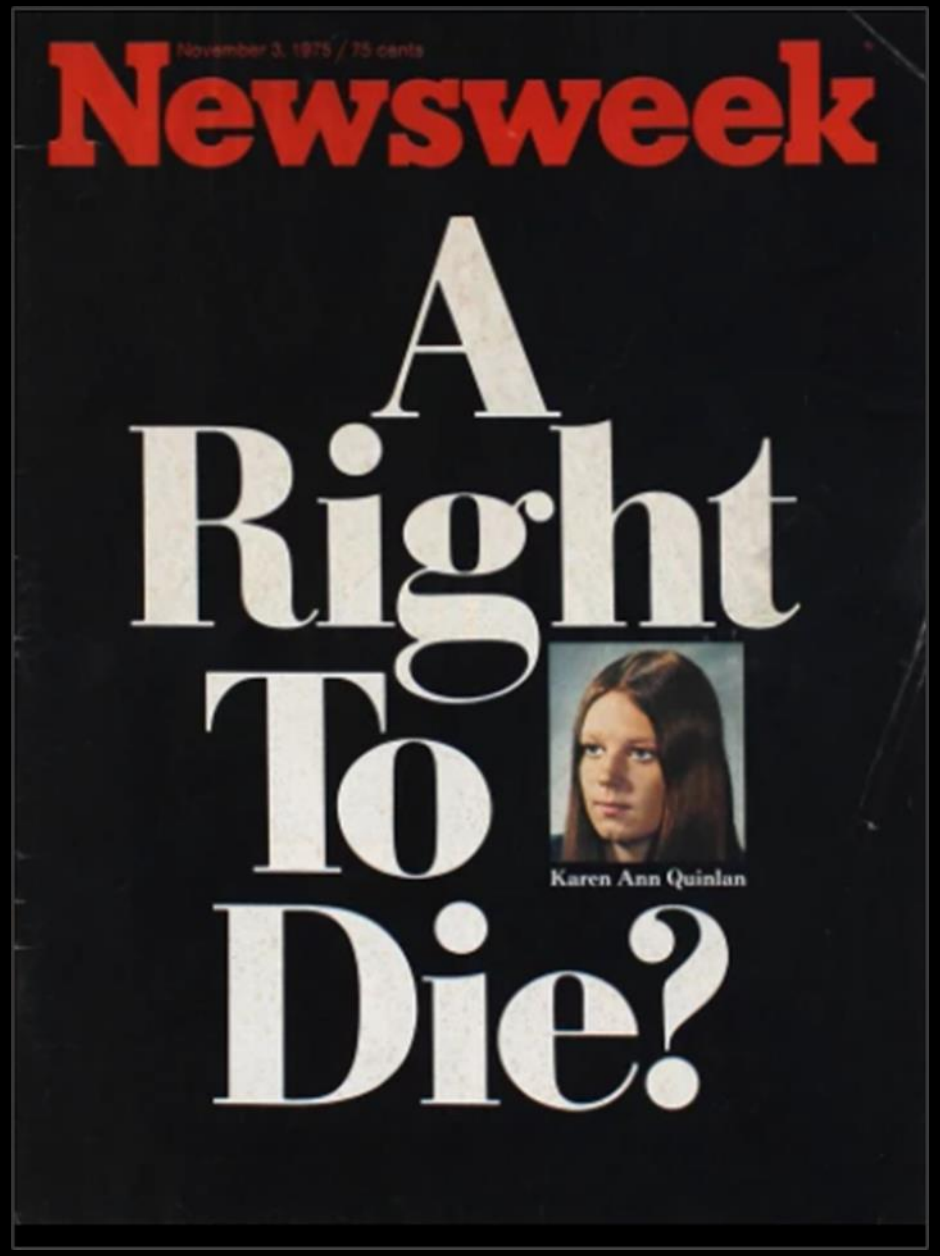
DENMARK, 1952

DENMARK, 1952

READ THE STORY HERE



SAVING LIFE PROLONGING DEATH



THE STORY OF KAREN ANN QUINLAN

1975

MANY DOCTORS, AFTER ALL, ARE TAUGHT TO REGARD **DEATH AS AN ENEMY** AND TO DO ALL THEY CAN TO DEFEAT IT—OR AT LEAST TO KEEP IT AT BAY FOR A WHILE.

MANY REGARD "PULLING THE PLUG" AS AN ACT AKIN TO EUTHANASIA, WHICH IS FORBIDDEN BY BOTH LAW AND THE MEDICAL CODE.

"THERE IS A PROFOUND DIFFERENCE BETWEEN KILLING SOMEONE

AND ALLOWING SOMEONE TO SPEND HIS OR HER LAST FEW HOURS OR DAYS FREE

FROM THE MAZE OF MACHINERY THAT IS BEAUTIFUL

ONLY SO LONG AS THERE IS HOPE FOR SOME RECOVERY."

RIGHT TO PRIVACY

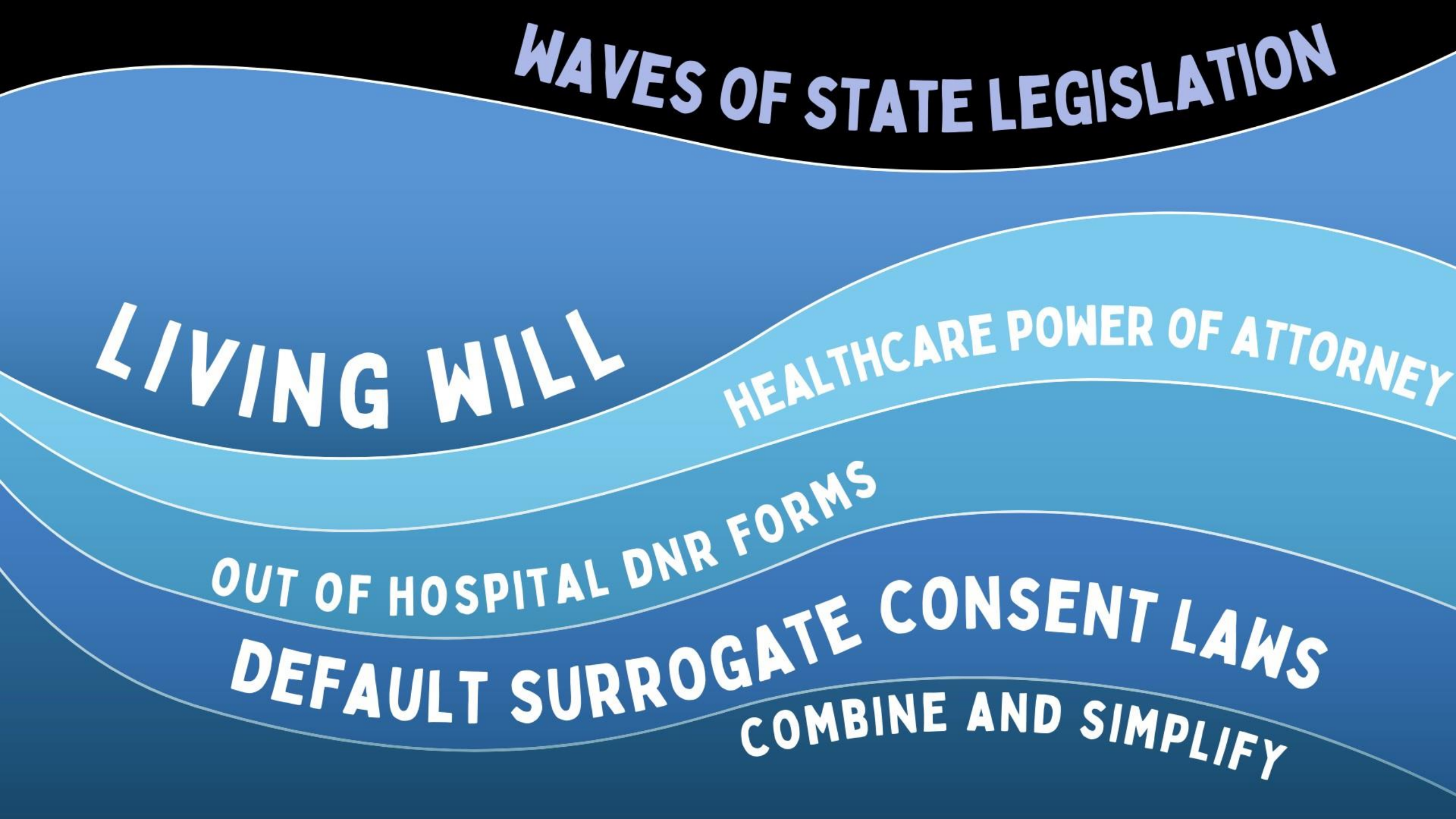
RIGHT TO PRIVACY

FATHER HAD RIGHT TO DECIDE
NOT DOCTORS NOT COURTS

RIGHT TO PRIVACY

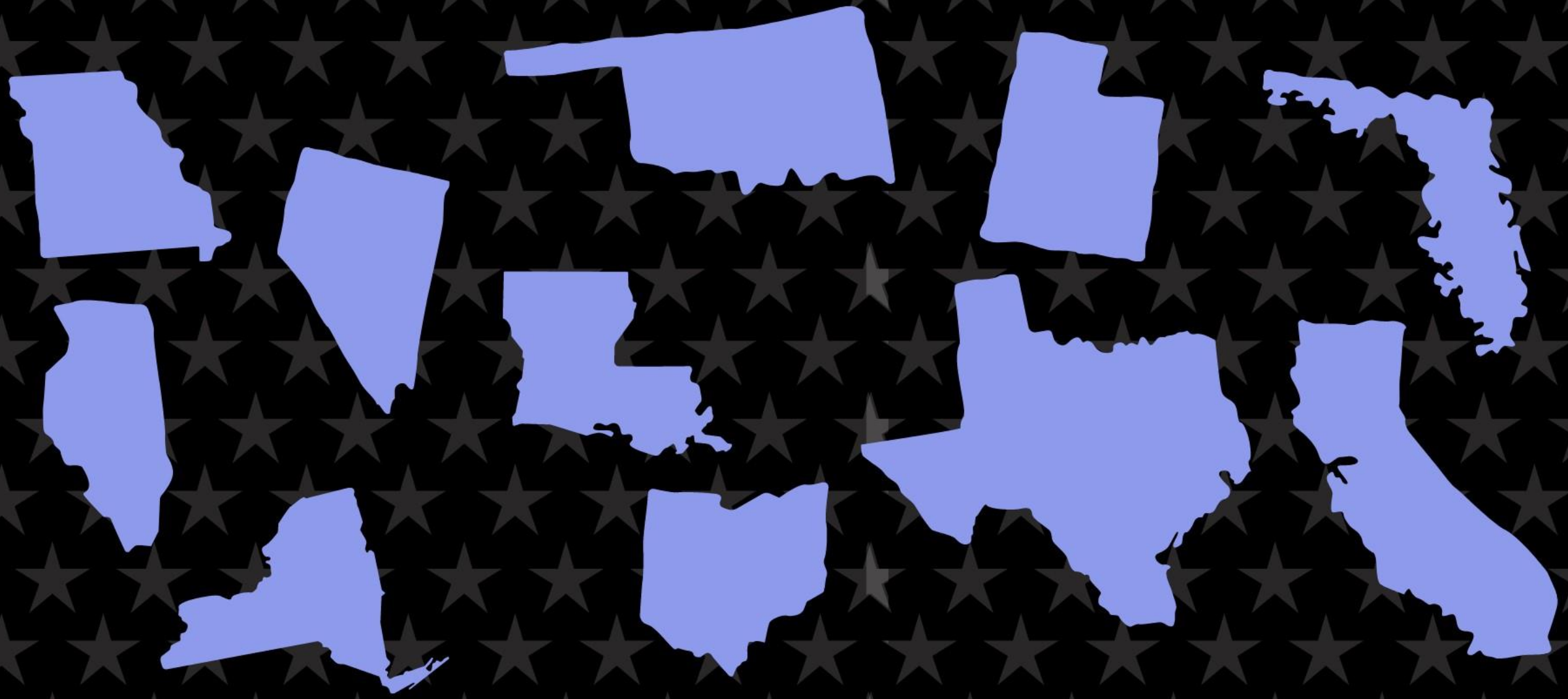
FATHER HAD RIGHT TO DECIDE
NOT DOCTORS NOT COURTS

NOT HOMICIDE
DEATH FROM NATURAL CAUSES


WAVES OF STATE LEGISLATION
LIVING WILL
HEALTHCARE POWER OF ATTORNEY
OUT OF HOSPITAL DNR FORMS
DEFAULT SURROGATE CONSENT LAWS
COMBINE AND SIMPLIFY

STATES WRITE ADVANCE DIRECTIVE LAWS

SO YOU'LL NEED TO LEARN THE LAWS OF THE STATES IN WHICH YOU PRACTICE



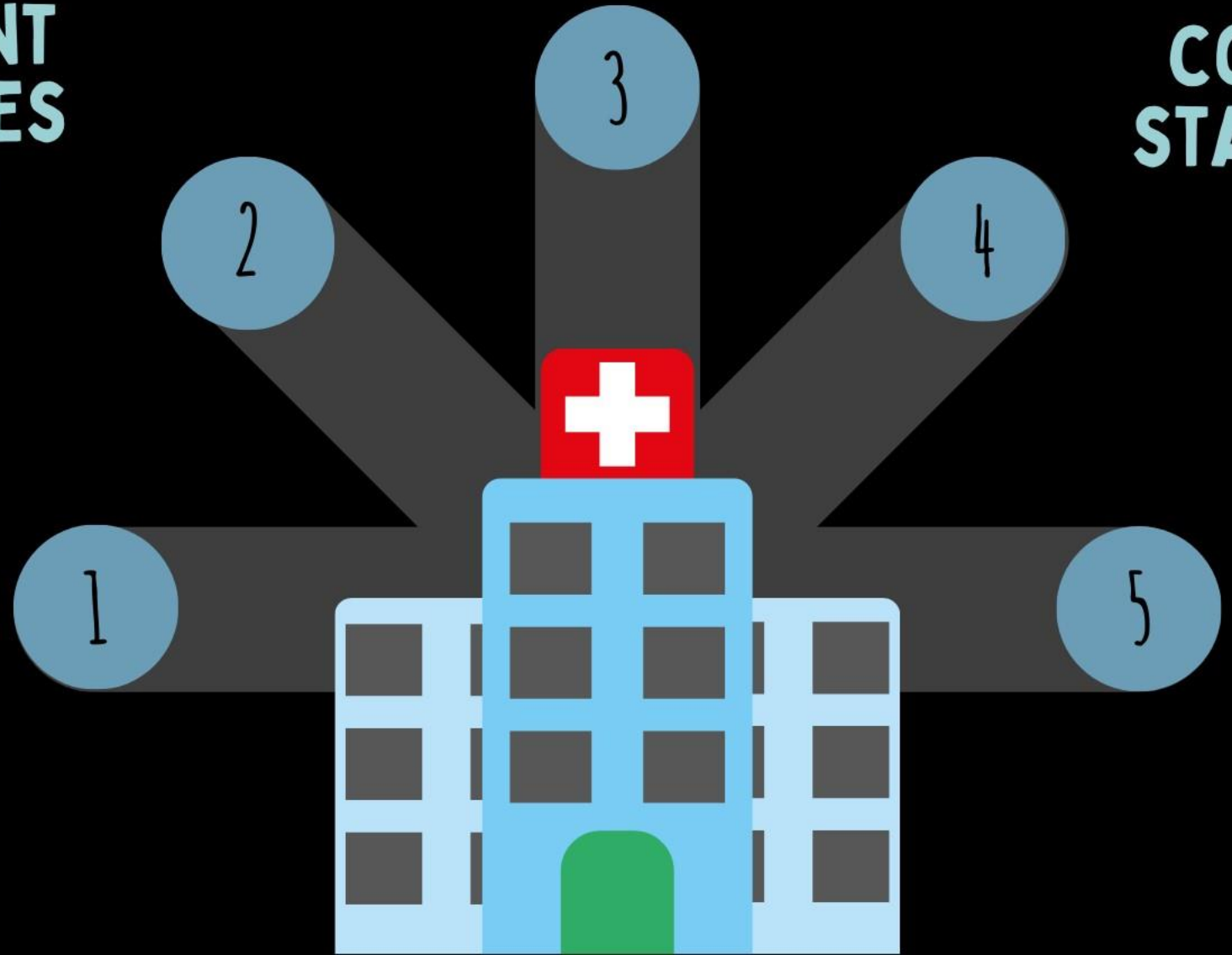
FEDERAL LEGISLATION
EDUCATION AND GUIDANCE

PATIENT SELF-DETERMINATION ACT 1990

DO NOT DISCRIMINATE

DOCUMENT DIRECTIVES IN EMR

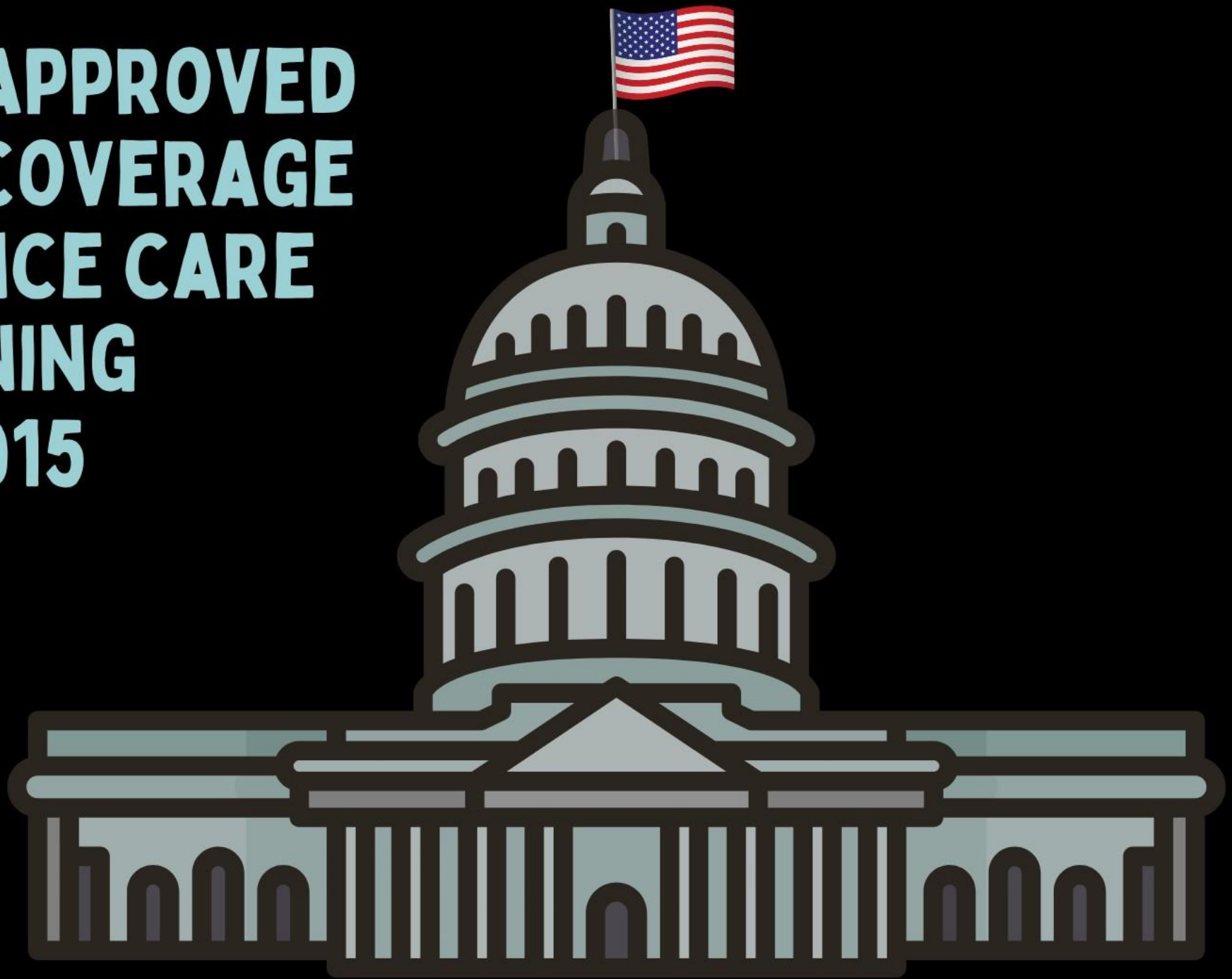
COMPLY WITH STATE AD LAWS



INFORM PATIENTS ABOUT RIGHTS

EDUCATE STAFF AND COMMUNITY

CONGRESS APPROVED MEDICARE COVERAGE FOR ADVANCE CARE PLANNING IN 2015



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)
COUNTY OF _____)

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)
COUNTY OF _____)

DECLARATION OF A DESIRE FOR A NATURAL DEATH

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LEGAL TRANSACTIONAL

COMMUNICATIONS BASED

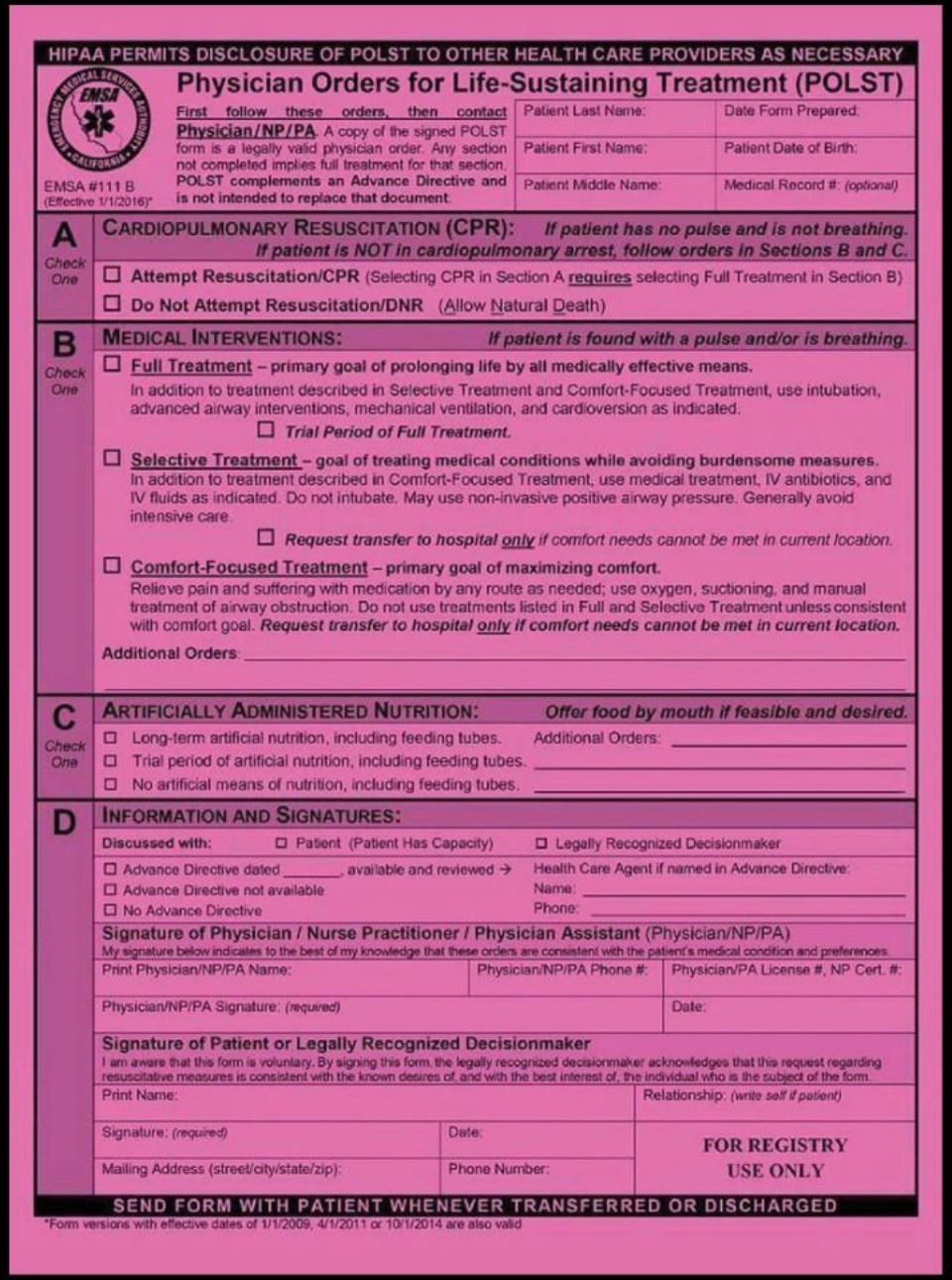
1980 | 1990 | 2000 | 2010 | 2020

POLST

FIVE WISHES

POLST

PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT



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

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

Physician Orders for Life-Sustaining Treatment (POLST)

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.
- ☐ Trial period of artificial nutrition, including feeding tubes.
- ☐ No artificial means of nutrition, including feeding tubes.

Additional Orders: _____

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

POLST COMMUNICATES A PATIENT`S WISHES AS MEDICAL ORDERS

SIGNED BY A PHYSICIAN OR ADVANCED PRACTICE CLINICIAN

POLST IS NOT FOR EVERYONE

AND

DIAGNOSED WITH A SERIOUS ILLNESS

EXPECTED TO LOSE CAPACITY WITHIN 12 MONTHS

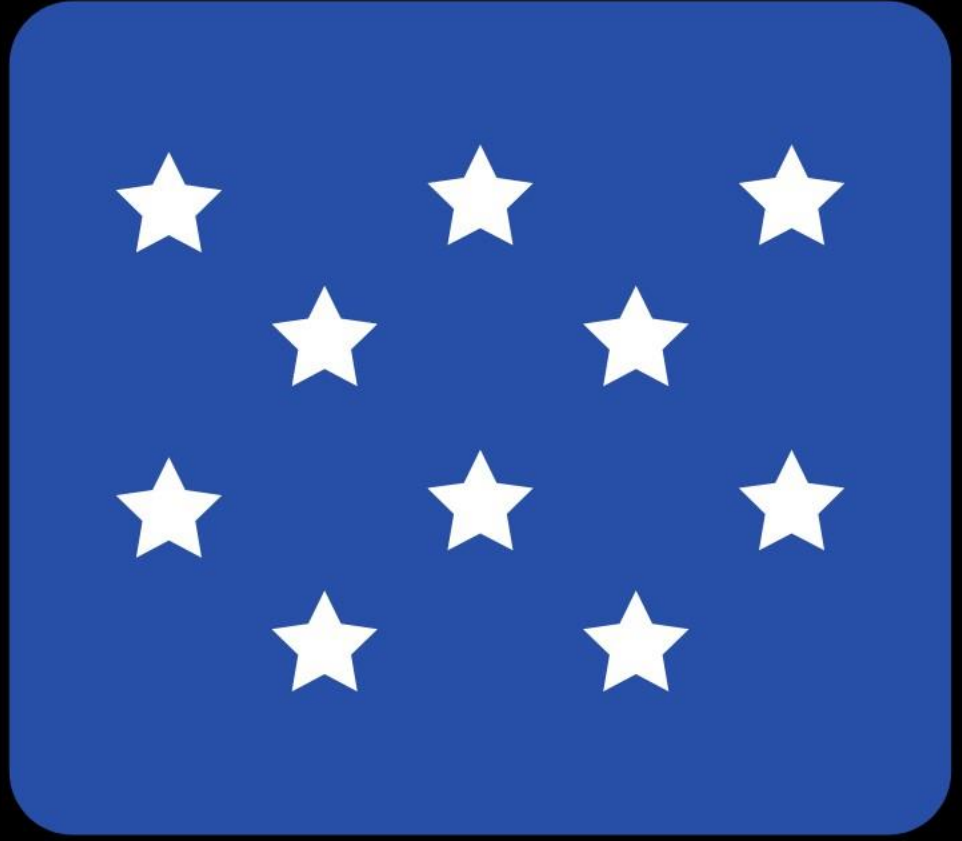
VERY HEALTHY

LEAST HEALTHY

STANDARD CARE

LEGAL DOCUMENTS

MEDICAL ORDERS



POLST POST MOST

MOLST DMOST IPOST

TPOPP LAPOST MI-POST

MPOST OKPOLST PAPOLST COLST WYOPOLST

POST

PHYSICIANS' ORDERS FOR SCOPE OF TREATMENT

dhec

South Carolina Physician Orders for Scope of Treatment (POST)

Patient Last Name:	**Patient First Name/MI:**
Patient Date of Birth: (MM/DD/YYYY)	**Patient/Legal Representative Phone Number:**
Social Security Number last 4 digits: (*Optional*) XXX-XX-	**Gender:** ☐ M ☐ F ☐ Other
Patient Mailing Address: (street/city/state/zip)	
Patient's Diagnosis:	

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Unresponsive, pulseless, & not breathing.

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

If patient is not in cardiopulmonary arrest, follow orders in **B**, **C** and **D**.

Section B *Check One Box Only*

MEDICAL INTERVENTIONS: If patient has pulse and/or is breathing.

- ☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. ***Transfer to hospital and/or intensive care unit if indicated.***
  Treatment Plan: All treatments including breathing machine.
- ☐ **Limited Treatment.** In addition to care described in Comfort Measures Only, use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airways interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). ***Transfer to hospital, if indicated. Avoid ICU if possible.***
  Treatment Plan: Provide basic medical treatments.
- ☐ **Comfort Measures Only.** Keep clean, warm and dry. Provide treatments to relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. ***Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location.***
  Treatment Plan: Provide treatments for comfort through symptom management.

Additional Orders:

Section C *Check One Box Only*

ANTIBIOTICS

- ☐ Use antibiotics if life can be prolonged.
- ☐ Determine use or limitation of antibiotics when infection occurs.
- ☐ No antibiotics except for relief of pain and discomfort.

Additional Orders:

Section D *Check One Box in Each Column*

ARTIFICIALLY ADMINISTERED NUTRITION AND FLUIDS: Offer food and fluids by mouth if feasible.

☐ Long-term artificial nutrition by tube.	☐ Long-term IV fluids.
☐ Trial period of artificial nutrition by tube.	☐ Trial period of IV fluids.
☐ Do not insert feeding tube.	☐ No IV fluids.
☐ Decide when/if the situation arises.	☐ Decide when/if the situation arises.
Additional Orders:	**Additional Orders:**

Section E *Signature of Physician, APRN, or PA*

Signature of Physician, Advanced Practice Registered Nurse, or Physician Assistant

My signature below indicates to the best of my knowledge that the patient has been diagnosed with a serious illness or, based upon a medical diagnosis, may be expected to lose capacity within 12 months, and that these orders are consistent with the patient's medical condition, diagnosis, and preferences.

Physician/APRN/PA Signature: *(required)*	Physician/APRN/PA Name: *(print)*	☐ Physician ☐ APRN ☐ PA (*Select one*)
Date: (MM/DD/YYYY) *(required)*	Physician/APRN/PA Phone Number:	Physician/APRN/PA License #:

Check everyone who participated in discussion: ☐ Patient with decision-making capacity ☐ Legal Representative ☐ Other:

Section F *Signature of Patient or Legal Representative*

Signature of Patient or Legal Representative

I am aware that this form is voluntary. I agree that adequate information has been provided and significant thought has been given to life-prolonging measures. Treatment preferences have been expressed to the physician, physician assistant, or advanced practice registered nurse and this document reflects those treatment preferences. *If signed by a legal representative, preferences expressed must reflect patient's wishes as best understood by the legal representative.*

Signature: *(required)*		Relationship: (*write "self" if patient*)
Print Name:	Date: (MM/DD/YYYY) *(required)*	Phone Number:

Section G *Facilitator (if applicable)*

Facilitator Assisting with POST Form Completion (if applicable)

Print Name:	Date: (MM/DD/YYYY)	Phone Number:

FORM MUST ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

POST Form ****ATTACH to Page 1****

Patient Full Name:

Form Completion Information (Optional but Helpful)

Reviewed patient's advance directive to confirm no conflict with POST form: (A POST form does not replace an advance directive such as a Health Care Power of Attorney or living will.)	☐ Yes; date of the document reviewed: _____ ☐ Conflict exists, notified patient (if patient lacks capacity, noted in chart) ☐ Advance directive not available ☐ No advance directive exists

- A POST form is a designated document designed for use as part of advance care planning, the use of which must be limited to situations where the patient has been diagnosed with a serious illness or, based upon medical diagnosis, may be expected to lose capacity within 12 months and consists of a set of medical orders signed by a patient's physician, APRN, or PA addressing key medical decisions consistent with patient goals of care concerning treatment at the end of life that is portable and valid across health care settings.
- A POST form executed in South Carolina as provided in the POST Act, or a similar form executed in another jurisdiction in compliance with the laws of that jurisdiction, must be deemed a valid expression of a patient's wishes as to health care. A South Carolina health care provider or health care facility may accept a properly executed POST form as a valid expression of whether the patient consents to the provision of health care in accordance with Section 44-66-10, et seq. of the South Carolina Adult Health Care Consent Act.
- The effective date of the form is the date the POST form has been completed, executed, and signed by the Physician/APRN/PA and the patient or the patient's legal representative.
- A copy, facsimile, or electronic version of a completed POST form is considered to be legal.
- **The execution of a POST form is always voluntary and is for a person with an advanced illness.** The POST form records a patient's wishes for medical treatment in the patient's current state of health. Preferred medical treatment as stated by the patient on the POST form may be changed at any time by the patient or a designated health care representative or health care agent of the patient to reflect the patient's new wishes in accordance with the POST Act.
- Any physician who is responsible for the creation and execution of a POST form shall make reasonable efforts to periodically review and update the POST form with the patient as the patient's needs dictate but at least once per year.
- A patient's legal representative is defined under the POST Act to mean a person with priority to make health care decisions for patient pursuant to Section 44-66-10, et seq. of the South Carolina Adult Health Care Consent Act.
- An APRN may create, execute and sign a POST form if authorized to do so by his or her practice agreement. The POST form must be for a patient of the APRN, the physician with whom the APRN has entered into a practice agreement, or both.
- A PA may create, execute, and sign a POST form if authorized to do so by his or her scope of practice guidelines. The POST form must be for a patient of that PA, the PA's supervising physician, or both.

Revocation of POST Form

- A POST form may be revoked at any time by an oral or written statement by the patient or a patient's legal representative.
- A revocation is only effective upon communication to the health care provider or health care facility by the patient or the patient's legal representative.
- The execution of a POST form by a patient, or the patient's legal representative, pursuant to the POST Act, automatically revokes any previously executed POST form.
- A POST form executed pursuant to the POST Act remains effective until revoked or until a new POST form is executed pursuant to the POST Act.

Nothing herein shall be construed as legal advice.

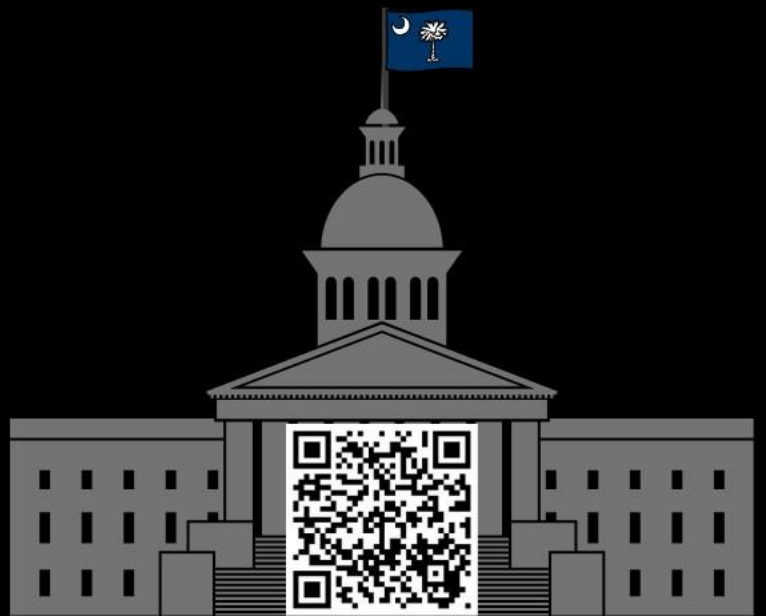
FORM MUST ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

DHEC 4061 (02/2020) SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL

A HEALTH CARE PROVIDER...

WHO IN GOOD FAITH COMPLIES WITH A POST FORM,
IS NOT SUBJECT TO CRIMINAL PROSECUTION, CIVIL LIABILITY OR
DISCIPLINARY PENALTY FOR COMPLYING WITH THE POST FORM

EXECUTED IN ACCORDANCE WITH THIS CHAPTER AND THE ADULT HEALTH CARE CONSENT ACT.



PHYSICIAN ORDERS FOR SCOPE OF TREATMENT ACT

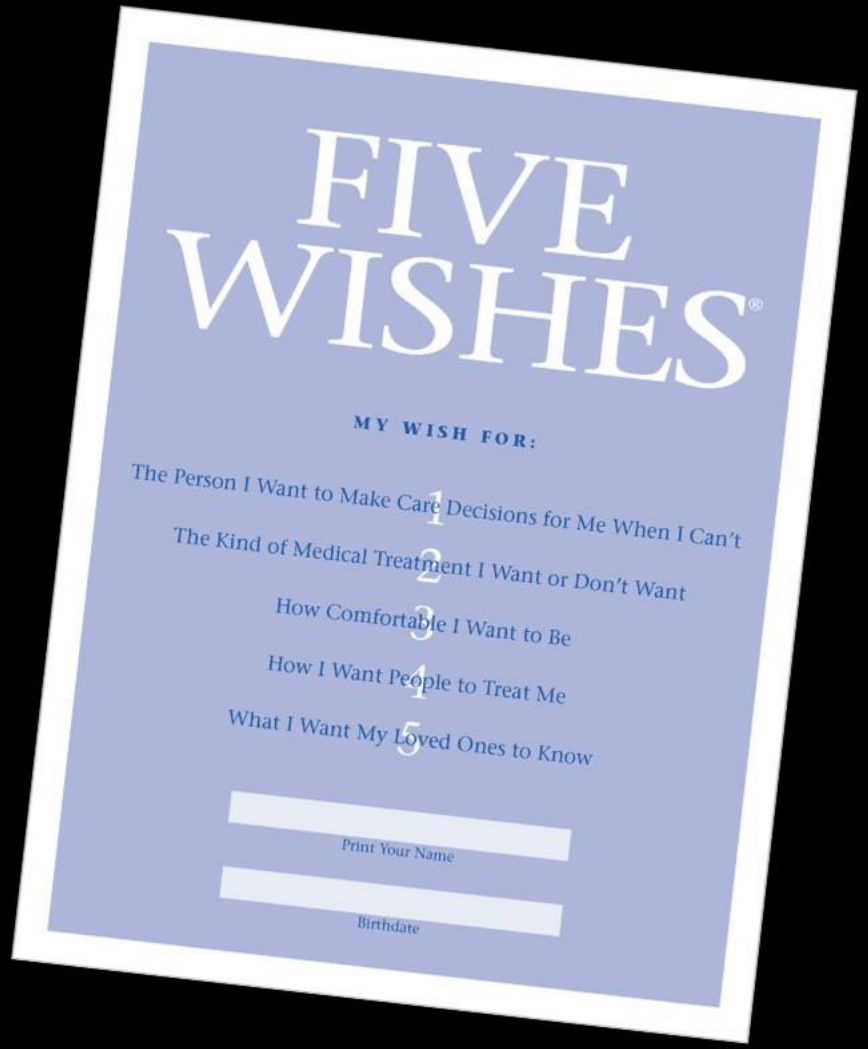
AGING WITH DIGNITY

FIVE WISHES

2010

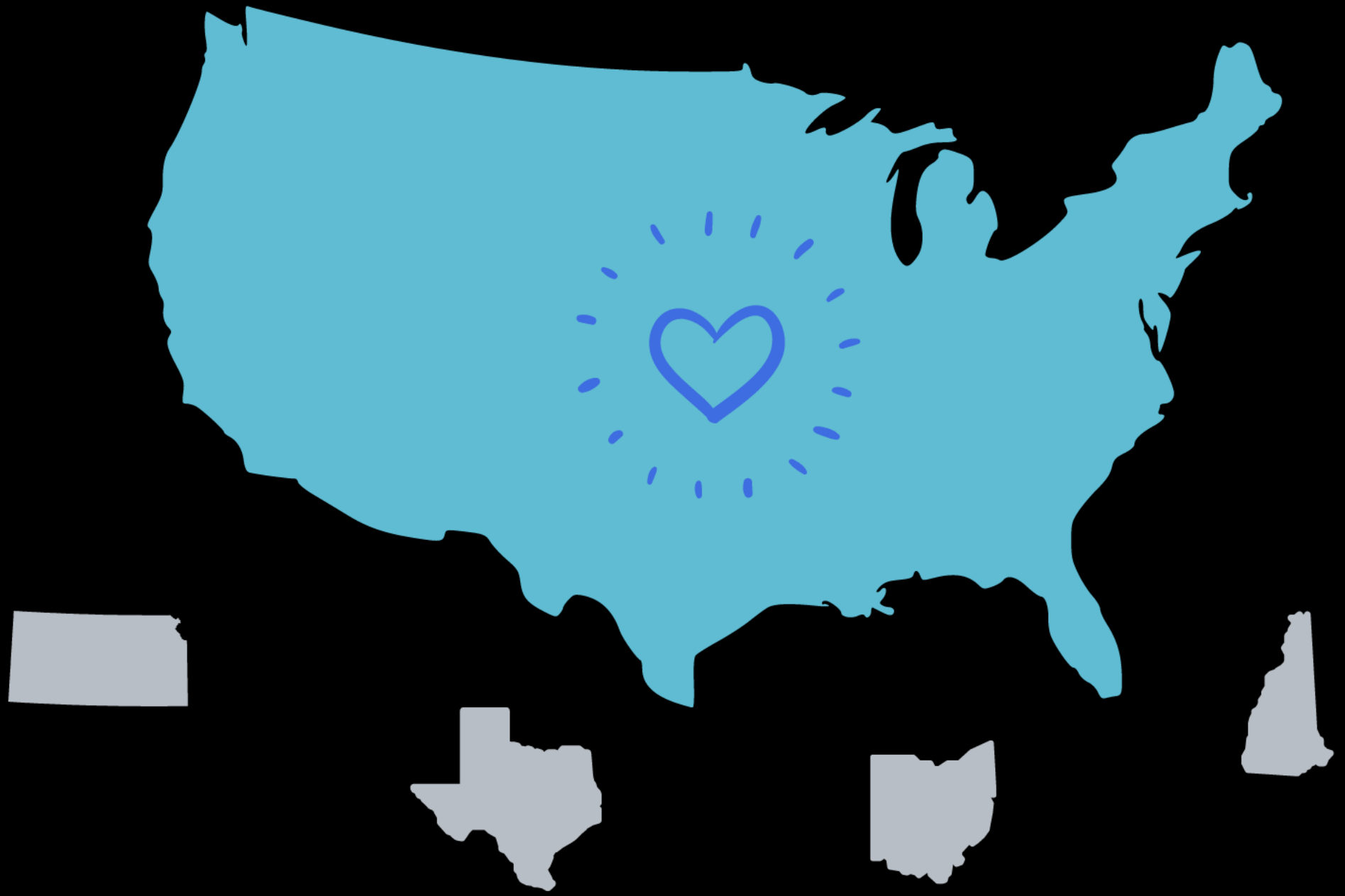
ABA COMMISSION ON LAW AND AGING

EXPERTS IN EOL CARE



SEE SAMPLE HERE


FIVE WISHES
DOES MEET
SOUTH CAROLINA
REQUIREMENTS
FOR A LIVING
WILL.



FIVE WISHES

MY WISH FOR:

1. THE PERSON I WANT TO MAKE CARE DECISIONS FOR ME WHEN I CAN`T
2. THE KIND OF MEDICAL TREATMENT I WANT OR DON`T WANT
3. HOW COMFORTABLE I WANT TO BE
4. HOW I WANT PEOPLE TO TREAT ME
5. WHAT I WANT MY LOVED ONES TO KNOW

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

Address

City/State/Zip

Phone

Third Choice Name

Address

City/State/Zip

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.

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.

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.

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.)

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.

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):

_____

_____

_____

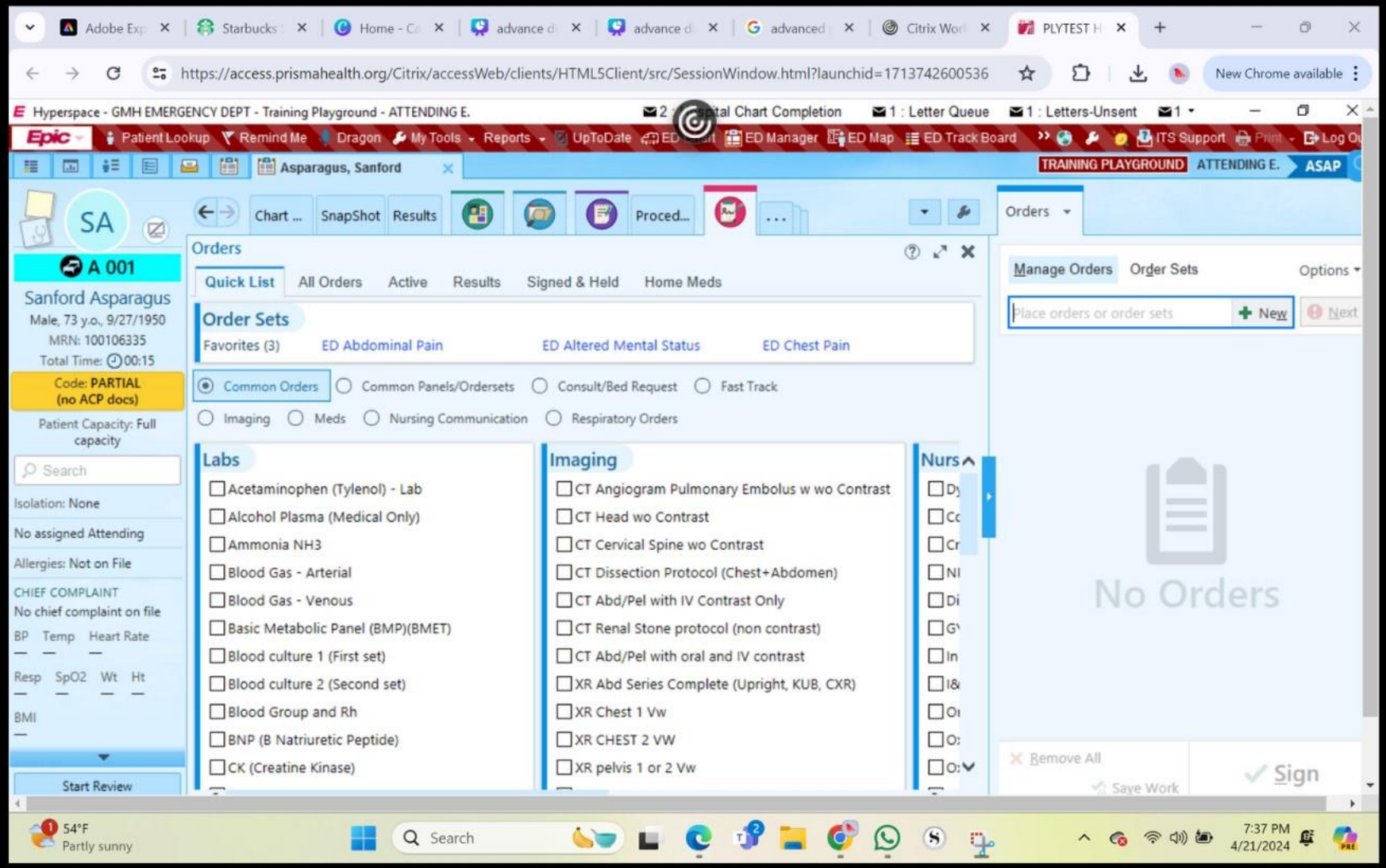
(Please use the space below for any other wishes. For example, you may want to donate any or all parts of your body when you die. You may also wish to designate a charity to receive memorial contributions. Please attach a separate sheet of paper if you need more space.)

_____

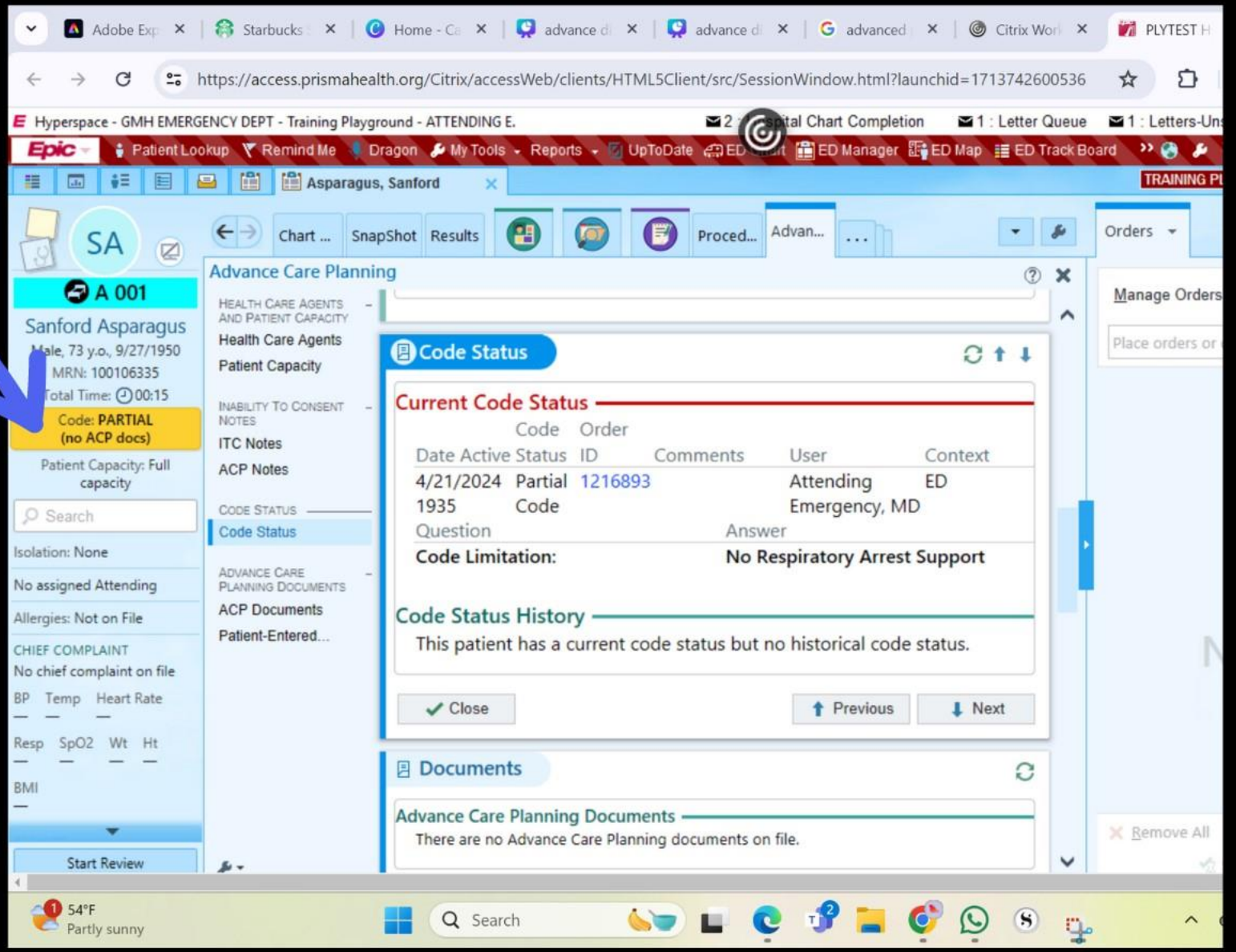
_____

_____

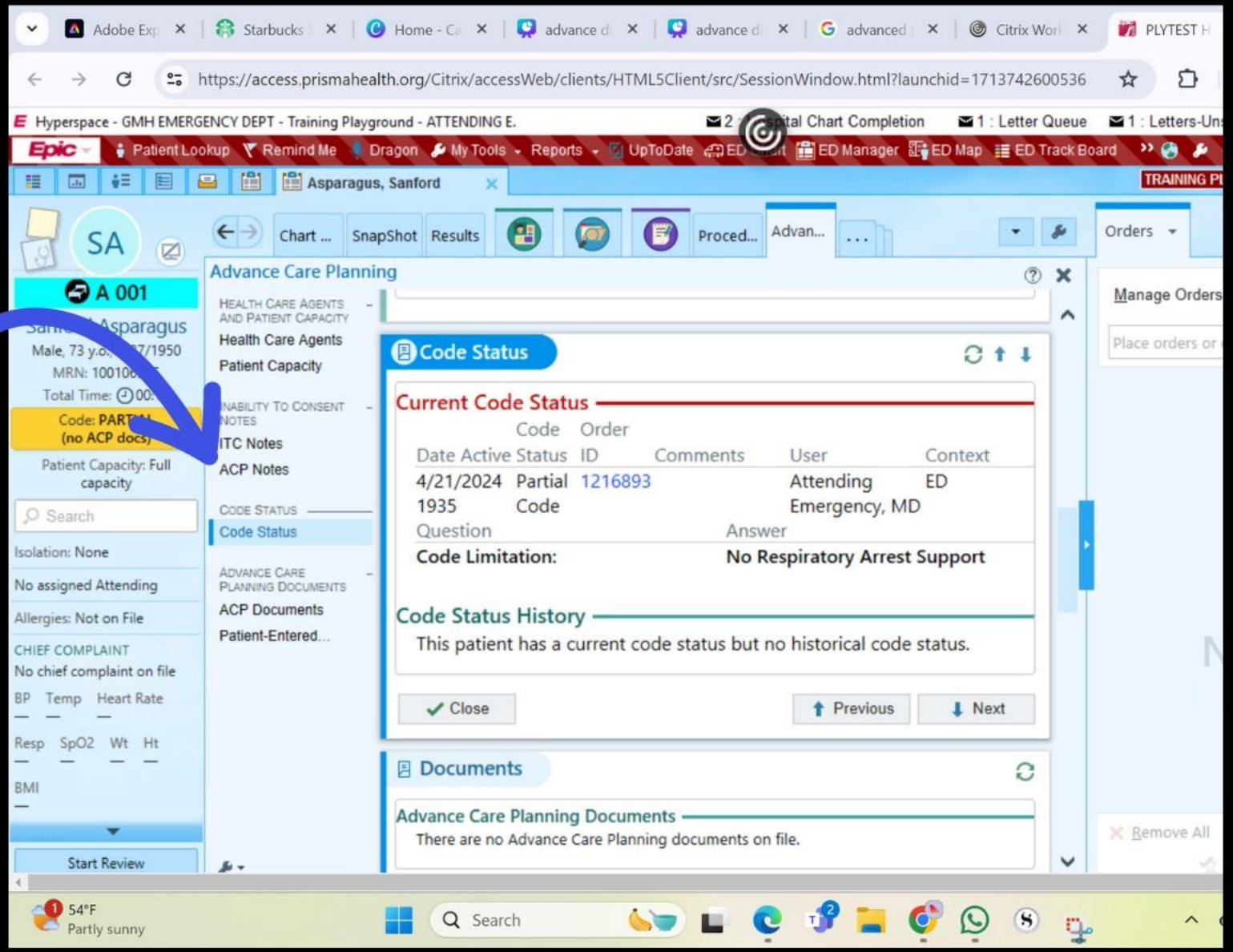
ADVANCE CARE PLANNING INFO IS HERE



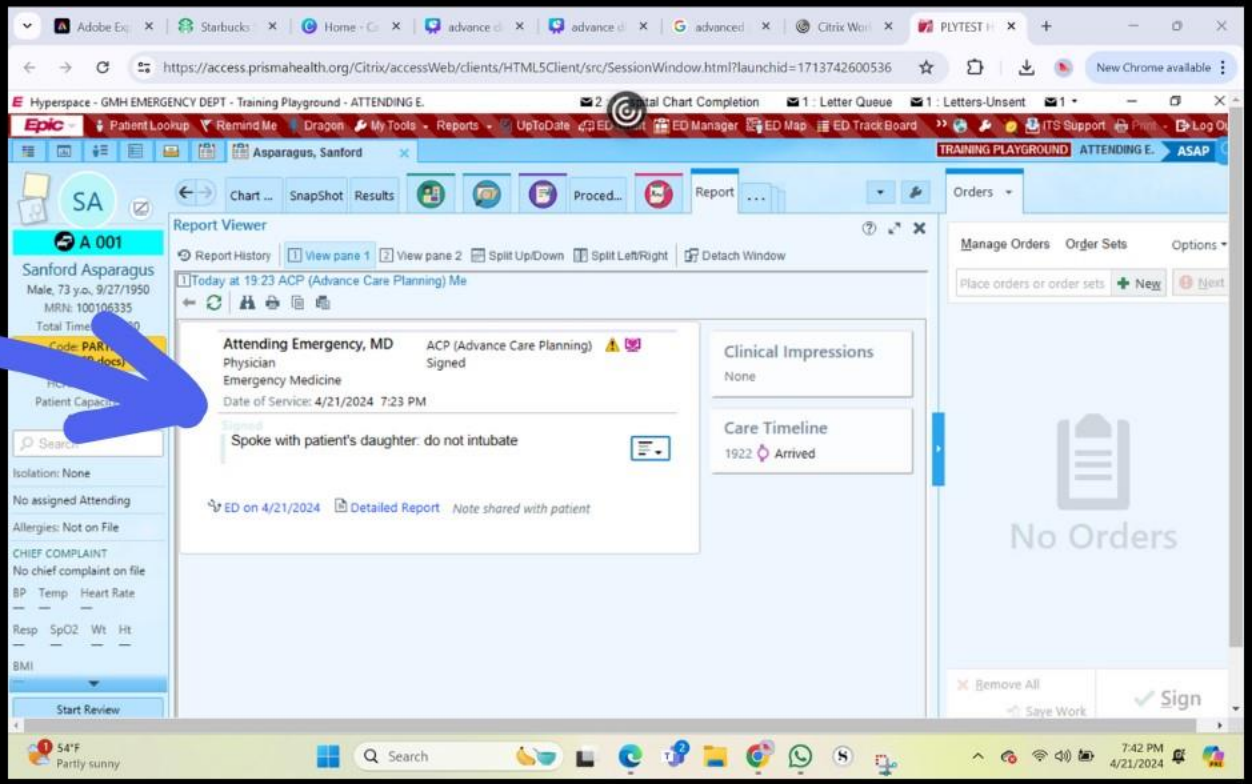
CLICK TO OPEN FOR MORE INFORMATION

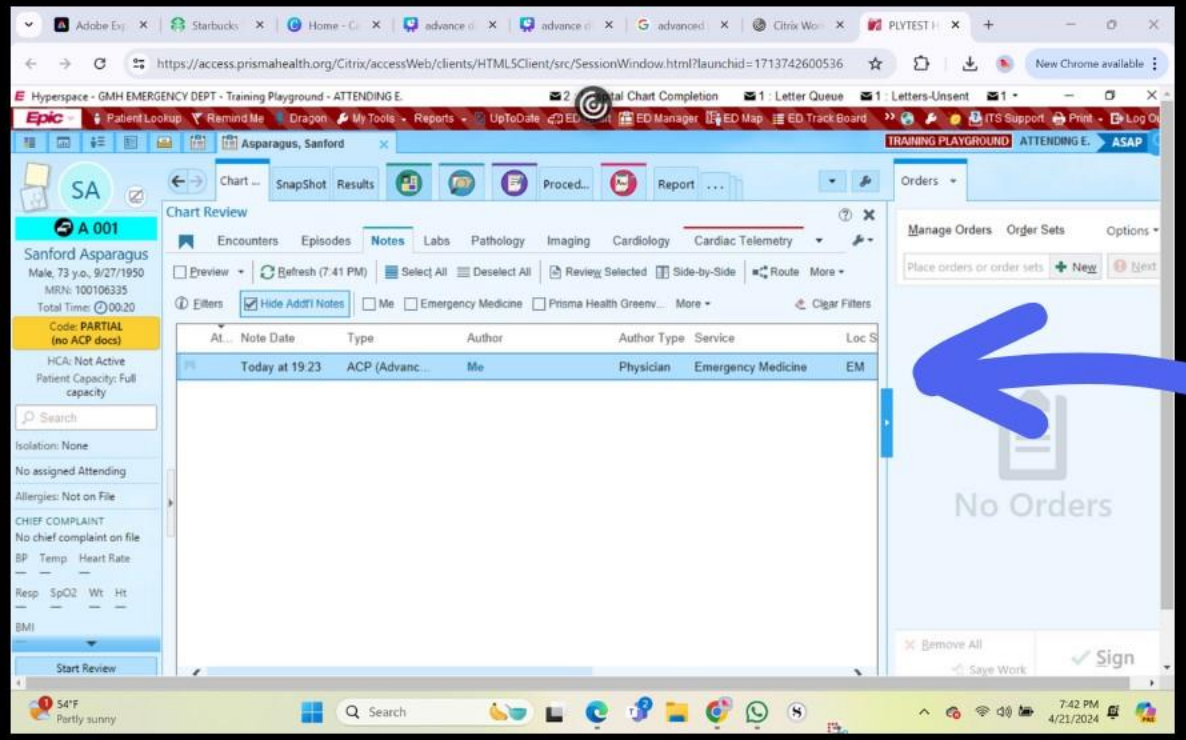


DOCUMENT YOUR SHARED DECISION MAKING



WRITE YOUR NOTE HERE





IT SHOWS UP IN THE SEARCHABLE DOCUMENT LIST

GO COMPLETE YOUR OWN ADVANCE DIRECTIVES

SC FORMS

FIVE WISHES

GO COMPLETE YOUR OWN ADVANCE DIRECTIVES

SC FORMS

FIVE WISHES