Triage Health Estate Planning Toolkit: Vermont

Part II: Understanding Estate Planning Documents in Your State

State Laws About Wills

A will is a legal document that provides instructions for what you would like to have happen to your property upon death. A will is also a place where parents can name a guardian for any minor children or adult children with developmental disabilities.

Vermont probate courts accept written wills. To make a valid written will in Vermont:

1. You need to be in the right state of mind to create a will. This means you need to be:
   - At least 18 years old, lawfully married, or a member of the U.S. armed or maritime services
   - Of "sound mind" (meaning you know what you're doing)
2. You need to sign the will, in front of two adult witnesses who have watched you sign or authorize someone else to sign the will, and understand what they are signing.
3. You might also want to make your will "self-proving," or accepted in probate court without the court needing to contact your witnesses. To do this, ask your witnesses to sign a statement that it was your intention to make the will and you did so without undue or coercive influence.

State Laws About Financial Powers of Attorney

A power of attorney for financial affairs is a legal document where you (the principal) name a trusted adult (the agent) who is authorized to make financial decisions on your behalf.

Vermont's general power of attorney allows you to choose someone to manage your finances, including assets like your property, taxes, and government benefits. You can also choose an alternate agent, who will take charge separately if the first person cannot act. This person can make all financial decisions for you, or you can limit their powers to specific areas, like filing taxes or banking. This document can take effect immediately after you sign it and remain in effect if you become incapacitated, or you can indicate you would like it to end if you become disabled. You can revoke your power of attorney at any time.

Part III of this toolkit includes a sample form.

State Laws About Advance Health Care Directives

An advance health care directive (AHCD) is a legal document you can use to provide written instructions, or state preferences, about your medical care in case you become unable to communicate. The **Vermont Advance Directive** contains nine parts. You can complete some or all of these parts depending on your advance planning needs.

- **Part 1: Appointment of Agent:** You can choose someone (an agent) to make decisions about your medical care for you, including life-prolonging care, any time your doctor determines you can no longer make these decisions. You can also choose an alternate person if the first person you appoint is not available. This

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document takes effect any time your doctor determines you can no longer understand or communicate your preferences for health care, unless you specify that it should take effect immediately after signing or if a specific condition or event occurs (e.g., you develop Alzheimer's disease)

- **Part 2: Others Who Are or May Become Involved in My Care:** This section allows you to specify who may and may not be involved in determining your health care, including doctors and other people who your agent can consult about your care.
- **Part 3: Statement of Values and Goals:** In this section, you can describe the values and goals that should guide your health care.
- **Part 4: End of Life Wishes** You can share your preferences for health care if you become unable to speak for yourself and are suffering from a terminal illness or unconsciousness. You can clarify your preferences for treatments including surgery or other invasive procedures, cardiopulmonary resuscitation (CPR) to restart your heart or breathing, antibiotics, dialysis, chemotherapy, and artificially-supplied nutrition and hydration. If you like, you can indicate that you want your agent to make these decisions. You can also indicate whether or not you would like to make an organ donation.
- **Part 5: Other Treatment Wishes:** In this section, you can record your wishes for treatment other than at the end of life, including **Do Not Resuscitate Orders (DNR)**.
- **Part 6: Waiver of Right to Request or Object to Future Treatment:** In this section, you can indicate that you want people to disregard or ignore your responses when offered health treatment in the future. If you want to use this section, it will require additional signatures from your health care agent, your doctor, and someone designated to explain this section to you (e.g., attorney, ombudsman, clergy member.)
- **Part 7: Organ and Tissue Donation:** Here you can indicate your wishes about organ and/or tissue donation.
- **Part 8: Disposition of My Body After Death:** This section allows you to provide directions about funeral arrangements or related wishes about what happens to your remains after you die. You can also appoint an agent to handle arrangements or indicate that family members should make these decisions.
- **Part 9: Signing and Witnessing Provisions:** You must sign your AHCD in front of two adult witnesses. Neither witness can be your spouse, agent, parent, sibling, child, grandparent, or a beneficiary of you will. If you are a resident in a hospital, nursing home, or other care facility, a third person designated by your facility will also have to sign to certify you know what you are doing.

You can revoke your declaration at any time by:

- Signing and dating a written statement revoking your declaration
- Personally informing your doctor and having them add a note to your record
- Destroying the declaration or asking someone else to do so for you
- Creating a new advance health care directive

Part III of this toolkit includes a sample advance health care directive.

State Laws About POLST/MOLST

A physician order for life-sustaining treatment (POLST) is a medical order completed by a seriously ill person and signed by a physician. In Vermont, this document is called a Vermont Do Not Resuscitate Order/Clinical Order for Life-Sustaining Treatment (DNR/COLST). The DNR/COLST does not replace an advance directive. You can complete a DNR/COLST form with your doctor.

This form lets you indicate your preferences for:

- Cardiopulmonary resuscitation orders (this is your "Do not resuscitate," or DNR order)
- Intubation and mechanical ventilation

- Hospital transfers
- Antibiotics
- Medically assisted nutrition and hydration, or food and water offered through surgically-placed tubes
- Medical Interventions, ranging from all medical and surgical treatments available to prolong your life, selective treatments to restore your health while avoiding burdensome procedures, or comfort-focused treatments to manage symptoms and allow natural death
- Other instructions for your care

This form will not expire, so it is important for you and your physician to review it regularly to make sure it still reflects your wishes.

Part III of this toolkit includes a sample form.

State Laws About Funeral Designation Forms

Funeral designation forms allow you to tell your loved ones what you would like to happen to your remains after you pass away. These forms can be used to choose someone to control what happens to your remains after your death, specify what you would like to have happen, and other wishes depending on your state.

Part 8 of the Vermont Advance Directive allows you to indicate preferences for funeral planning and the disposition of your remains.

State Laws About Death with Dignity

"Death with Dignity" laws, or physician-assisted dying/aid-in-dying laws, allow certain terminally ill people to voluntarily and legally request and receive a prescription medication from their physician to hasten their death in a peaceful, humane, and dignified way. By adding a voluntary option to the continuum of end-of-life care, these laws can give you dignity, control, and peace of mind during your final days with family and loved ones.

As of 2013, Vermont's Patient Choice and Control at the End of Life Act allows adults with terminal illnesses to voluntarily request medication that would hasten death from their physicians. Qualified patients must:

- Be 18 years or older
- Be mentally competent, or able to make health care decision for themself
- Be diagnosed with an incurable terminal illness with a prognosis of six months or less to live
- Be able to take (eat, drink, swallow, or inject) the aid-in-dying medication by themself

While this law originally required someone to be a Vermont resident, as of May 2, 2023, the residency requirement was removed.

If you would like to request aid-in-dying medication, start by talking to your physician. Your conversation could include discussing alternative and additional therapies (like comfort care or pain management), ways to involve loved ones, and the effects and process of taking an aid-in-dying medication. After this conversation, you must:

- Verbally ask for the medication twice, at least 15 days apart.
- Submit a written request for the medication using the required form. This request should come after your second verbal request.
- After receiving all three requests, your doctor will refer you to another doctor to verify your diagnosis and prognosis. Once both doctors verify your prognosis and that you know what you are doing, your primary physician will administer the medication.

Once you receive your aid-in-dying medication, you can choose where you administer it. However, this cannot be done in a public place.

If your doctor refuses to administer an aid-in-dying medication, they are required to refer you to someone that will.

Taking aid-in-dying medications will not affect your life insurance policy, if you have one.

Federal Law About HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that protects the privacy of your health information. HIPAA does allow your protected health information to be shared with your personal representative who has authority to make health care decisions for you (i.e., your health care agent or proxy).

To guarantee your agent's access to information, a HIPAA authorization form should be signed and dated by you. Also, it must identify the information to be disclosed, the purpose of the disclosure, the recipients of the information, and an expiration date. This means that any advance health care directives should be clear about the scope of your agent's authority to receive protected health care information.

You can revoke a HIPAA authorization form at any time by notifying your health care provider in writing.

Part III of this toolkit includes a sample HIPAA authorization form. For more information: www.cdc.gov/phlp/publications/topic/hipaa.html.

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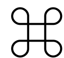
Triage Health Estate Planning Toolkit: Vermont

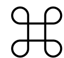
Part III: Your State's Estate Planning Forms

- Power of Attorney for Financial Affairs
- Advanced Health Care Directive
- Vermont Do Not Resuscitate Order/Clinical Order for Life-Sustaining Treatment (DNR/COLST)
- HIPAA Authorization Form

Triage Health Estate Planning Toolkit



Part III: Your State’s Estate Planning Forms



Power of Attorney for Financial Affairs

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GENERAL POWER OF ATTORNEY FOR FINANCIAL AFFAIRS

A Power of Attorney for Financial Affairs lets you designate someone to help you manage your money and property. You designate a person to be your "agent". You can give your agent broad powers to handle your property during your lifetime, or you can limit what your agent can do. This is your decision, and you can decide how you want your agent to act.

This document does not authorize anyone to make medical or other health care decisions for you. To do that, You need to execute an Advance Directive for health care decisions. That is a separate form you need to fill out and sign with witnesses.

This power of attorney may be revoked by you at any time. You can revoke it in writing, by telling your agent, or by tearing it up or crossing it out or any other act that shows you want it revoked. Tell your agent that you are revoking the power of attorney. You should also tell your bank and other financial institutions.

If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you. This form does not provide for all options allowed by the law. You may also wish to consult a lawyer to consider other options or to ensure that your power of attorney meets your needs. This document is intended to create a *general* power of attorney pursuant to 14 V.S.A. §3501 *et seq.* with full authority to act on my behalf.

APPOINTMENT OF AGENT

Your Name:____________________________________ **Date of Birth:**____________

Address: ____

____

City State Zip Code

I appoint the following person as my Agent:

Name: ____

Address: ____

To act in my name, place and stead in any way which I myself could do, if I were personally present, with respect to the matters and powers specified in this power of attorney, to the extent that I am permitted by law to act through an agent.

GENERAL POWERS

I give my Agent the full authority to handle my personal and financial affairs. This includes but is not limited to managing all my financial matters, including banking, investments, pensions, retirement accounts, taxes, trusts, and insurance; accessing all my information, accounts, and property; and performing any act relating to any matter, account, transaction or property, now owned or later acquired by me, as I have the right to manage, access or perform myself.

GENERAL POWER OF ATTORNEY FOR FINANCIAL AFFAIRS

EFFECTIVE DATE

You can decide whether you want this power of attorney to start today, or on a day in the future, or only when you can no longer make financial decisions for yourself. **Initial your choice below.**

_____ I want this power of attorney to start now.

_____ I want this power of attorney to start on this date: ________________________

_____ I want this power of attorney to start when I am found to lack the capacity to make financial decisions for myself by my doctor.

_____ I want this power of attorney to start when the following occurs (specify how this will be determined):

____

____

SPECIFIC POWERS

The general grant of powers will NOT grant the authority for your agent to act in the following areas. If you want your agent to be able to do these things, you must initial what you wish to choose. If you do not initial here, your agent will not be able to do these things.

In addition to the General Powers given to my agent in this Power of Attorney, I give my agent full authority to handle the following powers, as I have chosen by **initialing my choices below**:

_____ To convey lands and handle all real estate transactions relating to any real property I now own or have an interest in or which I may later acquire.

_____ To handle the following specific real estate transaction (describe the real property involved in the transaction and the nature of the transaction):

____

____

_____ To compensate him or herself with funds or property belonging to me for duties performed as Agent.

_____ To make gifts or loans to persons other than the Agent with funds or property belonging to me.

_____ To make gifts or loans with funds or property belonging to me to the Agent.

_____ To appoint another person as successor Agent under this Power of Attorney.

GENERAL POWER OF ATTORNEY FOR FINANCIAL AFFAIRS

LIMITATION ON THE POWERS OF THE AGENT

At all times my Agent must follow my directions specifically forbidding any action this power of attorney gives to my Agent, if I give those specific directions.

List any specific acts which you do not want your Agent to take on your behalf:

____

____

DURABLE POWER OF ATTORNEY

Important: If you want this Power of Attorney to remain in effect after you become disabled or incapacitated, you must make this a "durable" Power of Attorney. To do this, you must specifically say that you want a Durable Power of Attorney by **initialing below**.

_____ Yes. I want this Power of Attorney to be durable. The Power of Attorney shall not be affected by my subsequent disability or incapacity.

_____ No. I **do not** want this Power of Attorney to be durable. This Power of Attorney will terminate automatically if I become disabled or incapacitated.

ALTERNATE AGENT

If the Agent I named above is unable or unwilling to serve, I appoint this person as my alternative agent, to be my Agent with all powers and limitations described in this Power of Attorney:

Name: ____

Address: ____

ACCOUNTINGS

My Agent must keep a written record of all transactions taken under this power of attorney and must provide me with a written statement of all such transactions at any time upon my request.

Optional instructions about accountings:

____

____

____

RELIANCE OF THIRD PARTIES

Any person receiving a copy or facsimile of this power of attorney may act in reliance on it.

GENERAL POWER OF ATTORNEY FOR FINANCIAL AFFAIRS

Important: You must sign in the presence of a witness and a notary.
The witness and the notary may not be the same person.
The person named as the agent may not serve as the witness or notary.

SIGNATURE OF PRINCIPAL

I signed this Power of Attorney appointing my agent before a witness and notary.

______________________________ ______________________
You Sign Here **Date**

WITNESS

I declare that the principal appears to be of sound mind and free from duress at the time this Power of Attorney is signed. The principal has affirmed that he or she is aware of the nature of the document and is signing it freely and voluntarily.

______________________________ ______________________
Witness Signs Here Date

____
Print Name

____
Address

NOTARY

At ____________________ (Town), ______________________(State), the principal appeared personally before me and acknowledged that he or she had signed this Power of Attorney freely and voluntarily.

______________________________ ______________________
Notary signs here Date

GENERAL POWER OF ATTORNEY FOR FINANCIAL AFFAIRS

SIGNATURE OF AGENT

The agent does not have to sign at the same time as the principal, but the agent must sign prior to using the power of attorney for the first time.

I accept the authority granted to me as agent in this document, and understand the duties under the power and under the law.

______________________________________ ______________________
(Agent signs here) Date

INSTRUCTIONS TO AGENT

As an agent, Vermont Law imposes duties. Agents have what is known as a "fiduciary" duty to their principals. This means that an agent must act only for the benefit of the principal.
Below is a list of duties the agent must follow.

- Take no action beyond the authority given by the power of attorney document.
- Act in good faith.
- Refrain from doing things that benefit the yourself rather than the principal.
- Avoid any conflicts of interest which impair your ability to act as your agent.
- Keep your money and property separate from the principal's money and property.
- Keep records of all transactions and give the principal an accounting when the principal requests one.
- Follow any specific instructions from the principal, including an instruction forbidding an action, even if that action is authorized by the power of attorney document.
- Stop acting as agent immediately if the principal revokes the power of attorney or if something else happens which terminates the power of attorney.
- Exercise the degree of care that would be observed by a "reasonably prudent person".

GENERAL POWER OF ATTORNEY FOR FINANCIAL AFFAIRS

Distributing copies of Power of Attorney

You should keep the original of this document in a safe place.
Give your agent a copy of this document.
It is important to keep track of anyone you've given a copy of this document.
If you ever decide later that you want to revoke this Power of Attorney, you must provide notice to the people, organizations, and financial institutions you gave a copy of this power of attorney.

I have provided copies of this Power of Attorney to the following persons or organizations:

Name:____ Date copy given:_________________

Address:____

Name:____ Date copy given:_________________

Address:____

Name:____ Date copy given:_________________

Address:____

Name:____ Date copy given:_________________

Address:____

Name:____ Date copy given:_________________

Address:____

Name:____ Date copy given:_________________

Address:____

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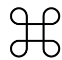
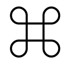


Part III: Your State’s Estate Planning Forms



Advance Health Care Directive

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Vermont Advance Directive for Health Care

— LONG FORM —

Explanation and Instructions

An Advance Directive is a document you prepare to choose someone as your health care agent or to guide others to make health decisions for you. An advance directive can include instructions about your health care as well as what should happen with your body after you die. Having an Advance Directive helps when you no longer can or no longer wish to make your own decisions. As you begin your Advance Directive, here are some important things to know:

- You have the right to consent to or refuse any medical treatment.
- You have the right to appoint an **agent** to make decisions for you.
- You may use this Advance Directive to share your wishes ***in advance***.
- You may fill out all Parts of this Advance Directive form or just portions of it. For example, you can just appoint an agent in Part 1 and then sign Part 9. If you choose not to appoint an agent, you can skip part 1 and just give instructions in other Parts that you wish to fill out. However, if you fill out any Part of this document, you must also fill out Part 9, as it provides signatures and witnesses to validate the Advance Directive.
- You may use any Advance Directive form or format as long as it is properly signed and witnessed.
- You can revoke or suspend your Advance Directive at any time unless you expressly waive your right to do so.

Everyone could benefit from having an Advance Directive — not just those anticipating the end of their lives. Any of us could have an accident or suffer from an unexpected medical condition. Some of us live with a mental or physical illness that leaves us without capacity at times. Without an Advance Directive, those making decisions for you will not know what your wishes are. Worse still, your family and friends could fight over the care you should get. Help them help you — fill out and sign an Advance Directive.

This Advance Directive has 9 Parts. Fill out as few or as many Parts as you like today. If you want, you can fill out other Parts another day. This is *your* document: change it as you like so that it states your wishes in your own words. You may cross out what you don't like and add what you want.

Note: For copying and storing purposes only the actual form pages, not the instructions, have consecutive page numbers. When sending copies, you need send only the numbered pages of the form itself.

Updating your Advance Directive

It is very important that the information in your Advance Directive is always current. Review it once a year or when events in your life change. Consider the "5 D's" as times when your Advance Directive might need to be changed or updated. The 5 D's are: Decade birthday, Diagnosis, Deterioration, Divorce or Death of somebody close to you or that affects you. All of these events may affect how you think about future health care decisions for yourself.

Whenever necessary, you should also update addresses and contact information for your agent and alternate agent and other people such as potential medical guardians whom you may have identified in your Advance Directive.

Revoking or Suspending your Advance Directive

You may revoke your Advance Directive by completing a new Advance Directive or completing replacement Parts of this Advance Directive. Then the old Advance Directive or Part is no longer in effect and the new one replaces it. If the new one and the old one cover different subjects, then both will be in effect.

Suspending an Advance Directive is when you want a provision to not be in effect for a period of time. For example, you may have said you wanted a DNR order and the order may have been given to you. Then you need to go in for surgery and want the understanding that you will be revived during surgery if your heart stops.

You may revoke or suspend all or part of your Advance Directive by doing any of the following things:

1. Signing a statement suspending or revoking the designation of your agent;
2. Personally informing your doctor and having him or her note that on your record;
3. Burning, tearing, or obliterating the Advance Directive either personally or at your direction when you are present; or
4. For any provision (other than designation of your agent), stating orally or in writing, or indicating by any other act of yours that your intent is to suspend or revoke any Part or statement contained in your Advance Directive.

Appointment of My Health Care Agent

Appointing an agent to make decisions for you may be the single most important part of your Advance Directive. Your agent must be at least 18 years old and should be someone you know and trust. The person you choose should be someone who can make decisions for you, based upon your wishes and values. You ***cannot*** appoint your doctor or other health care clinician to be your agent. If you are in a nursing home or residential care facility, staff or owners cannot be your agents unless they are related to you. You can appoint an **alternate agent** to make decisions for you if your original agent is unavailable, unable, or unwilling to act for you. You can also appoint co-agents if you wish. (If you appoint co-agents, use the second page of Part 1 of this form.)

The authority of your agent to make decisions for you can begin:

- when you no longer have the ***capacity*** to make decisions for yourself, such as when you are unconscious or cannot communicate, or
- ***immediately*** upon signing the advance directive *if you so specify*, or
- when a ***condition*** you specify is met, such as a diagnosis of a debilitating disease such as Alzheimer's Disease or serious mental illness, or
- when an ***event*** occurs that you want to mark the start of your agent's authority, such as when you move to a nursing home or other institution.

The authority of your agent will *end* when you regain capacity to make your own decisions or you may specify when you want your Advance Directive to be no longer in effect.

Once your Advance Directive goes into effect, your agent will have access to all your medical records and to persons providing your care. *Unless you state otherwise* in written instructions, your agent will have the same authority to make all decisions about your health care as you have.

Your agent will be obligated to follow your instructions when making decisions on your behalf to the extent that they apply. If you choose not to leave explicit written directions in other Parts of your Advance Directive, the persons making health care decisions for you will be guided by knowledge of your values and what is in your best interest at the time treatment is needed.

Advance Directive

MY NAME .... DATE OF BIRTH .... DATE SIGNED................

ADDRESS ....

CITY ..

STATE .... ZIP...........................

PHONE .... EMAIL...

Part 1: My Health Care Agent

1. I want my agent to make decisions for me: (choose one statement below*)
   _____ when I am no longer able to make health care decisions for myself, or
   _____ immediately, allowing my agent to make decisions for me right now, or
   _____ when the following condition or event occurs (to be determined as follows):
   ____

   ** Normally these statements are separate choices, but it is conceivable that they could be concurrent.*

2. I appoint ______________________ as my health care Agent to make any and all health care decisions for me, *except to the extent that I state otherwise in this Advance Directive.*
   (You may cross out the italicized phrase if authority is unrestricted.)

   Address: ____
   Relationship (optional): ____
   Tel. (daytime): ______________________ (evening): ______________________
   cellphone: ______________________ email: ______________________

3. If this health care agent is unavailable, unable or unwilling to do this for me, I appoint ____ to be my Alternate Agent.

   Address: ____
   Relationship (optional): ____
   Tel. (daytime): ______________________ (evening): ______________________
   cellphone: ______________________ email: ______________________

   And if my Alternate Agent is unavailable, unable or unwilling to do this, I appoint ____ as my Next Alternate Agent.

   Address: ____
   Relationship (optional): ____
   Tel. (daytime): ______________________ (evening): ______________________
   cellphone: ______________________ email: ______________________

4. _____ I want to appoint two or more people to be co-agents and have listed them on page two of this Part.

Appointment of "co-agents"

You can appoint co-agents — people you ask to make decisions for you, acting together, based upon a discussion of your circumstance and agreement on a course of action or treatment. Sometimes co-agents have difficulty making decisions together. Before completing this part, be sure this is the best choice for you and your co-agents.

Not all of the people you ask to be co-agents may be readily available to speak for you or to make decisions that have to be made immediately, particularly in an emergency. For this reason, it is a good idea to give additional directions about how decisions can be made by your co-agents.

5. Co-agents I appoint are:

Name: ______________________ Relationship (optional): ______________
Address: ____
Phone (specify work, home or cell): ______________________________

Name: ______________________ Relationship (optional): ______________
Address: ____
Phone (specify work, home or cell): ______________________________

Name: ______________________ Relationship (optional): ______________
Address: ____
Phone (specify work, home or cell): ______________________________

(repeat below for additional co-agents)

6. I prefer that decisions made by the co-agents named above be made in the following way (you may choose one or prioritize 1,2,3):

_____ by agreement of all co-agents
_____ by a majority of those present, or
_____ by the first person available, if it is an emergency.

7. Other Instructions for co-agents (optional):

____
____
____
____
____
____

Others who may be involved in my care.

Part 2 is where you can list your current doctor or clinician with address and phone number. This will help by identifying someone who knows your medical history.

You can also state who else should or should ***not*** be consulted about your care.

You can state who is to be given information about your medical condition. This list might include your children, even if they are minors, or your close friends. Hospitals are required to withhold information about your condition from people unless you or your agent gives permission that this can be shared.

You can state who shall not be able to challenge decisions about your care in court actions. Normally any “interested individual” can bring an action in Probate Court regarding decisions made on your behalf. “Interested individuals” are your spouse, adult child, parent, adult sibling, adult grandchild, reciprocal beneficiary, clergy person or any adult who has exhibited special care and concern for you and who is personally familiar with your values. If there is someone in that list that you do ***not*** want to be able to bring an action to protect you, you may record the name of that person in Part 2.

Sometimes a court appoints a guardian for a person who is unable to manage aspects of his personal care or financial affairs. You can state a preferred person that you would like the court to appoint if this occurs in the future. That person could be the same person you chose as an agent or it could be someone else. You can also identify persons you would ***not*** want appointed as a future guardian for you.

Name ______________________________ DOB ____________ Date ___________

Part 2: Others Who Are or May Become Involved in My Care

1. My Doctor or other Health care Clinician:

   Name: ______________________ Address: ______________________
   Phone: ______________________ ______________________
   (or)
   Name: ______________________ Address: ______________________
   Phone: ______________________ ______________________

2. Other people whom my agent ***may*** be consulted about medical decisions on my behalf:

   ____
   ____

   Those who should ***not*** be consulted by my agent include:

   ____
   ____

3. My health agent or health care provider may give information about my condition to the following adults and minors:

   ____
   ____

4. The person(s) named below shall NOT be entitled to bring a court action on my behalf concerning matters covered by this Advance Directive nor serve as a health care decision maker for me.

   Name: ______________________ Address: ______________________

5. If I need a **guardian** in the future, I ask the court to consider appointing the following person:

   _____ My health care agent
   _____ The following person:

   Name: ______________________ Address: ______________________
   Phone: ______________________ ______________________

   You may also list alternate preferred guardians, or persons that you would not want to have appointed as guardians.

   Alternate preferred guardians: ______________________________

   Persons I would not want to be my guardian: ______________________
   ____

Statement of Values and Goals

Part 3 allows you to state in your own words what is most important to you as you think about medical care you may receive in the future. This will guide your agent and your health care providers and will let them know why you think particular choices are important based upon your own values and beliefs.

If you choose to fill out this Part, you may wish to use the **Worksheet 1: Values Questionnaire** that is in the Vermont Ethics Network booklet *Taking Steps* for help in framing and sharing your response.

You may also wish to use **Worksheet 2: Medical Situations and Treatment**. The second worksheet helps you consider how you might respond to changing circumstances and the changing chances that medical treatment may be successful.

Name ______________________________ DOB ______________ Date ____________

Part 3: Statement of Values and Goals

Use the space below to state in your own words what is most important to you.

____
____
____
____
____
____
____
____
____
____
____
____

…. And general advice about how to approach medical choices depending upon your current or future state of health or the chances of success of various treatments.

____
____
____
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____
____
____
____
____
____

End of Life Wishes.

Part 4 contains statements that you can use to express either a desire for continued treatment or a desire to limit treatment as death approaches or when you are unconscious and unlikely to regain consciousness.

Part 4 allows you to include other things that may be important to you, such as the type of care you would want and where you hope to receive that care if you are very ill or near the end of your life.

There may be other issues about health care when death is not expected or probable. These treatment issues and choices you can address in Parts 5 and 6 if you wish.

There may be questions about your survival that even doctors cannot predict accurately in your case. It is important to repeat that Part 4 is for those situations where you are ***not*** likely to survive or to continue living without life-sustaining treatment on a long-term basis.

Name ____ DOB _____________ Date ____________

Part 4: End-of-Life Treatment Wishes

If the time comes when I am close to death or am unconscious and unlikely to become conscious again (choose all that apply):

1. _____ I **do** want all possible treatments to extend my life.

– *or* –

2. _____ I **do not** want my life extended by any of the following means:

_____ breathing machines (ventilator or respirator)
_____ tube feeding (feeding and hydration by medical means)
_____ antibiotics
_____ other medications whose purpose is to extend my life
_____ any other means
_____ Other (specify) ______________________________

3. _____ I want my **agent to decide** what treatments I receive, *including tube feeding*.

4. _____ I want care that preserves my dignity and that provides **comfort and relief** from symptoms that are bothering me.

5. _____ I want **pain medication** to be administered to me even though this may have the *unintended effect* of hastening my death.

6. _____ I want **hospice care** when it is appropriate in any setting.

7. _____ I would prefer to **die at home** if this is possible.

8. Other wishes and instructions: (state below or use additional pages):

____
____
____
____
____
____
____
____
____
____

Other Treatment Wishes.

Part 5 addresses situations which may be temporary, long-term or which may be part of a health crisis that might become life ending for you if no treatment was given or if it was unsuccessful.

You may want to state your wishes regarding a **"Do Not Attempt Resuscitation" Order (DNR Order)** if your heart were to stop (statement 1). Such an order must be written and signed by your doctor. Either the completed written order, or a special bracelet or other identification of that order, needs to be available for any emergency first responders who are called to the scene when your heart stops. It is up to you or your agent to make sure that these additional steps are taken, including having your doctor complete and sign the order and give you either a copy of the order or some other identification.

You may be in a situation in which there is a chance for recovery but, without treatment, you might die. Statement 2 is about allowing a **"trial of treatment"** in situations like these. This means you want to start treatments that will sustain your life, such as breathing machines or tube feeding, to see if you will recover. If these life sustaining treatments are not successful after a period of time, you give your agent and other care providers permission to stop or withdraw them.

Other statements in this Part concern your wishes about hospitalization and treatment as well as participation in medical student education, or clinical or drug trials as part of your treatment.

There is also a statement about mental health treatment and your preferences concerning types of involuntary treatment.

Statement 9 of this Part concerns specific directions for prescribing and conducting electro-convulsive therapy (ECT) sometimes called "electro-shock" treatment.

If certain statements of Part 5 do not concern or apply to you, do not feel you have to address them. If you have an agent, that person will make decisions for you should the need arise.

NAME ______________________________ DOB ______________ DATE ____________

PART 5: OTHER TREATMENT WISHES

1. _____ **I wish to have a Do Not Resuscitate (DNR) Order** written for me.

2. _____ If I am in a critical health crisis that may not be life-ending and **more time is needed** to determine if I can get better, I want treatments started. If, after a reasonable period of time, it becomes clear that I will ***not*** get better, I want all life extending treatment ***stopped***. This includes the use of breathing machines or tube feeding.

3. If I am conscious but become **unable to think or act for myself** and will likely not improve, I do not want the following life-extending treatment:
   _____ breathing machines (ventilators or respirators)
   _____ feeding tubes (feeding and hydration by medical means)
   _____ antibiotics
   _____ other medications whose purpose is to extend life
   _____ any other treatment to extend my life
   _____ Other: ________________________________

4. _____ If the likely **costs, risks and burdens** of treatment are more than I wish to endure, I do not want life-extending treatment. The costs, risks and burdens that concern me the most are: ________________________________

5. _____ If it is determined that I am **pregnant** at the time this Advance Directive becomes effective, I want:
   _____ all life sustaining treatment. (or)
   _____ only the following life sustaining treatments:
      ____ breathing machines (ventilators or respirators)
      ____ feeding tubes (feeding and hydration by medical means)
      ____ antibiotics
      ____ other medications whose purpose is to extend life
      ____ any other treatment to extend my life
      ____ Other: ________________________________
   _____ No life sustaining treatment

6. **Hospitalization** — If I need care in a **hospital or treatment facility**, the following facilities are listed in order of preference:

   Hospital/Facility: ____________________ Tel: ____________________
   Address.:____________________ ____________________

   Hospital/Facility: ____________________ Tel: ____________________
   Address.:____________________ ____________________

   Reason for preference: ________________________________

   I would like to ***Avoid*** being treated in **the following facilities**:

   Hospital/Facility: ____________________ Reason:____________________

   Hospital/Facility: ____________________ Reason:____________________

7. **I prefer the following medications or treatments**: Use more space or additional sheets for this section, if needed.

   ____

   Avoid use of the following medications or treatments: (List medications/treatments)

   ______________________________ Reason: ______________________________

   ______________________________ Reason: ______________________________

8. Consent for **Student Education, Treatment Studies or Drug Trials**

   _____ I **do** / **do not** *(circle one)* wish to participate in student medical education.

   _____ I **do** / **do not** *(circle one)* wish to participate in treatment studies or drug trials.

   (or)

   _____ I authorize my agent to consent to any of the above.

9. **Mental Health Treatment**

   A. **Emergency Involuntary Treatment.** If it is determined that an emergency involuntary treatment must be provided for me, I prefer these interventions in the following order: (List by number as many as you choose. For example, 1 = first choice; 2 = second choice, etc. You may also note the type of medication and maximum dosage.)

   _____ Medication in pill form

   _____ Liquid medication

   _____ Medication by injection

   _____ Physical restraints

   _____ Seclusion

   _____ Seclusion and physical restraints combined

   _____ Other: ____

   Reason for preferences above (optional): ______________________________

   B. **Electro-convulsive Therapy (ECT) or "Electro-Shock Treatment"**: If my doctor thinks that I should receive ECT and I am not legally capable of consenting to or refusing ECT, my preference is indicated below:

   _____ I **do NOT** consent to the administration of any form of ECT.

   _____ I **consent** / **do not consent** *(circle one)* to unilateral ECT

   _____ I **consent** / **do not consent** *(circle one)* to bifrontal ECT

   _____ I **consent** / **do not consent** *(circle one)* to bilateral ECT

   _____ I **consent** (or authorize my agent to consent) to ECT as follows:

   ____ I agree to the number of treatments the attending Psychiatrist considers appropriate.

   ____ I agree to the number of treatments Dr. ____________ considers appropriate.

   ____ I agree to the number of treatments my agent considers appropriate.

   ____ I agree to no more than the following number of treatments_____.

   Other instructions regarding the administration of ECT:

   ____

   _____ I acknowledge that I and my agent have been apprised of and will follow the uniform informed consent procedures and the use of standard forms to indicate consent to ECT per 18 V.S.A 7408.

Waiver of Right to Request or Object to Treatment

Part 6 is a special part that may be used by people who want their future responses to offered health treatment disregarded or ignored. **You must have an agent to fill out this Part.**

There may be situations in which you might be objecting to or requesting treatment but would then want your objections or requests *to be disregarded*. If you have had treatment in the past that scares you or is uncomfortable or painful you may be likely to say "no" when it is offered in a future health crisis. Still, you may know that this is the only way for you to come through a bad time or even survive. You understand that it is necessary and you would want it again if you had to have it. This Part will help you let your agent, and others know what you ***really*** want for yourself.

Because this is signing away a basic right that all patients have (to refuse or to request treatment) unless a court orders otherwise, you will need to give this much careful thought. You will also have to have additional signatures and assurances at the time you fill out this Part of your Advance Directive.

If you think Part 6 could apply to you and be helpful in your situation, you need to be sure that everyone involved in your care understands that you are making this choice of your own free will and that you understand the ramifications of waiving your right either to consent or to object to treatment.

Unlike other Parts of your Advance Directive, you can revoke Part 6 ***only when you have capacity to make medical decisions*** as determined by your doctor and another clinician.

For your agent to be able to make healthcare decisions over your objection, you must:

* Name your agent who is entitled to make decisions over your objection:__________________ ;
- Specify what treatments you are allowing your agent to consent to or to refuse over your objection;
- State that you either do or do not desire the specified treatment even over your objection at the time and, further, specify your wishes related to voluntary and involuntary treatment and release from that treatment or facility;
- Acknowledge in writing that you are knowingly and voluntarily waiving the right to refuse or receive specified treatment at a time of incapacity;
- Have your agent agree in writing to accept the responsibility to act over your objection;
- Have your clinician affirm in writing that you appeared to understand the benefits, risks, and alternatives to the proposed health care being authorized or rejected by you in this provision; and
- Have an **ombudsman, recognized member of the clergy, attorney licensed to practice in Vermont, or a probate court designee** affirm in writing that he or she has explained the nature and effect of this provision to you and that you appeared to understand this explanation and be free from duress or undue influence.

Name ____ DOB _____________ Date ___________

Part 6: Waiver of Right to Request or Object to Future Treatment

I hereby give my agent ___________________________ the authority to consent to or refuse the following treatment(s) over my objection if I am determined by two clinicians to lack capacity to make healthcare decisions at the time such treatment is considered:

1. **I *do* want** the following treatment to be provided, even over my objection, at the time the treatment is offered: ____

   I do *not* want the following treatment, even over my request for that treatment, at the time the treatment is offered: ____

2. I give permission for my agent to agree to have me admitted to a designated hospital or treatment facility even over my objection.

   _____ Yes _____ No

3. I give my agent permission to agree that my release from a voluntary admission for mental health treatment may be delayed even over my objection for up to four days so that a decision can be made regarding whether I meet criteria to be involuntarily committed.

   _____ Yes _____ No

4. I hereby affirm that I am knowingly and voluntarily waiving the right to refuse or request specified treatment at a time of incapacity, and that I understand that my doctor and one other clinician will determine whether or not I have capacity to make health care decisions at that time. I know that I can revoke this part of my Advance Directive only when I have the capacity to do so, as determined by my doctor and at least one other clinician.

Signed: ____ , Principal Date: _______________

(Continued next page)

Acknowledgements

Acknowledgement by Agent — I hereby accept the responsibility of consenting to or refusing the treatments specified above, even if to do so would be against the principal's expressed wishes at the time treatment is considered.

Signed: *(Agent)*____________________________ and *(Alternate)*____________________________

Print names:____________________________ ____________________________

Phone:____________________________ ____________________________

Date: ____________________________ ____________________________

Acknowledgement of principal's clinician — I affirm that the principal appears to understand the benefits, risks, and alternatives to the health care specified above that is being consented to or refused by the principal.

Signed: ____________________________ Title: ____________________________

Facility: ____________________________ Date:____________________________

Please print name:____

Acknowledgement by persons who explain Part 6 — I, as the designated person to explain Part 6, affirm that I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in Vermont, or a probate court designee and that I have:

- Explained the nature and effect of this Waiver of the Right to Request or Object to Treatment to the principal, and
- The principal appears both to understand the nature and effect of this provision and to be free from duress or undue influence.
- If the principal is in a hospital at the time of signing, that I am not affiliated with that hospital, and
- I am not related to the principal, a reciprocal beneficiary, or the principal's clergy or a person who has exhibited special care and concern for the principal.

Signed: ____

Position: ____________________________ Date: ____________________________

Organ and Tissue Donation

Part 7 of your Advance Directive allows you to state your wishes about organ and tissue donation.

In our country permission for organ donation is not assumed and often the family or next of kin are approached for donation at the time of an accidental or unexpected death. Although you may elect to have an agent or your family decide on organ and tissue donation, your organs are more likely to be used if you make the decision yourself.

You may also note your wishes on your license and attach the sticker showing that you wish to be an organ donor. You do not have to have an Advance Directive form filled out to show evidence of your wishes to be an organ donor, particularly if your license identification includes your wishes about organ donation.

If you wish to donate your body for research to a medical school you will first need to contact that institution to make separate arrangements and fill out forms supplied by that institution.

Name ____ DOB ______________ Date ____________

Part 7: Organ and Tissue Donation

I want my agent (if I have appointed one) and all who care about me to follow my wishes about organ donation if that is an option at the time of my death. *(Initial below all that apply.)*

_____ I wish to donate the following organs and tissues:

- ____ any needed organs or tissues
- ____ major organs (heart, lungs, kidneys, etc.)
- ____ tissues such as skin and bones
- ____ eye tissue such as corneas
- ____ I wish my agent to make any decisions for anatomical gifts (or)
- ____ I wish the following person(s) to make any decisions:

  ____

  ____

_____ I desire to donate my body to research or educational programs. (Note: you will have to make your own arrangements through a Medical School or other program.)

_____ I do not wish to be an organ donor.

Disposition of My Body after Death

Part 8 allows you to give directions about funeral arrangements or related wishes about the final disposition of your body after you die.

You can use the section to appoint an agent for making these arrangements, or you may say that family members should decide. You can give directions to whoever is in charge.

You can list important information about any pre-need arrangements you have made with a funeral home or cremation service or about the location of family burial plots.

You may indicate your permission to have an autopsy done on your body after your death. An autopsy is generally not suggested or needed when the cause of death is clear. If an autopsy is suggested, it could be helpful to your agent or family to know your wishes about having an autopsy performed. Autopsies may be ***required*** in cases where abuse, neglect, suicide or foul play is suspected.

Name ____________________ DOB ____________ Date ____________

Part 8: My Wishes for Disposition of my Body after my Death

1. My Directions for Burial or Disposition of My Remains after Death.

_____ I want a funeral followed by burial in a casket at the *following location, if possible* (please tell us where the burial plot is located and whether it has been pre-purchased):
____

(or)

_____ I want to be cremated and want my ashes buried or distributed as follows:
____

(or)

_____ I want to have arrangements made at the direction of my agent or family.

Other instructions:____________________
____
____

(For example, you may include contact information for Medical School programs if you have made arrangements to donate your body for research or education.)

2. **Agent** for disposition of my body *(select one)*:

_____ I want my **health care agent** to decide arrangements after my death;
if he or she is not available, I want my alternate agent to decide.
_____ I appoint the following person to decide about and arrange for the disposition of my body after my death:

Name: ____________________
Address: ____________________
Telephone: ____________________
Cellphone: ____________________ Email: ____________________

(or)
_____ I want my family to decide.

3. If an **autopsy** is suggested following my death:

_____ I support having an autopsy performed.
_____ I would like my agent or family to decide whether to have it done.

4. I have already made **funeral or cremation arrangements** with:

Name: ____________________
Address: ____________________
Telephone: ____________________

Signature and Witnesses

Congratulations! You have done much good work in sharing your wishes through the completion of your Advance Directive.

Be sure that your wishes as stated in the Parts you have chosen to fill out make sense when read together as a whole. If there is a question of conflicting wishes, be sure that you have indicated your priorities.

When you sign your Advance Directive, you must have **two adult witnesses**. Neither witness can be your spouse, agent, brother, sister, child, grandchild or reciprocal beneficiary. A change in Vermont law has made it a little easier to have witnesses available to assist you. For example, your health care or residential care provider and their staff now can be witnesses of Advance Directives.

If you are in a hospital, nursing home or residential care facility when you complete your Advance Directive, you will need a third person's signature to certify that he or she has explained the Advance Directive to you and that you understand the impact and effect of what you are doing. In a health care facility, this third person may be a hospital designee, a long-term care ombudsman, an attorney licensed to practice in Vermont, a clergyperson or a Probate Court designee. (Note: If you decide to include **Part 6** when you are in a health care facility, you must be sure that the third person who signs your document in that Part is not affiliated with or employed by the health care facility.)

Distribution of Copies of this Document

It is a good idea to make sure that your agent, your family, your personal physician and your nearest hospital or medical facility all have copies of this Advance Directive. List the people to whom you give copies at the end of Part 9 of the Advance Directive form. This will be make it easy for you to remember to tell all of these people if you decide to cancel, revoke or change this document in the future.

By mid-2007 you will also have the option to have your advance directive scanned into an electronic databank called an **Advance Directive Registry** where you, your agent, your health care facility and others you designate, can get copies of your advance directive (including special personal handwritten instructions) immediately.

Name ______________________________ DOB ____________ Date ____________

Part 9: Signed Declaration of Wishes

I declare that this document reflects my desires regarding my future health care, (organ and tissue donation and disposition of my body after death,) and that I am signing this Advance Directive of my own free will.

Signed: ______________________________ Date: ____________

(Optional) I affirm that I have given or will give copies of my Advance Directive to my Agent(s) and Alternate Agent(s) and that they have agreed to serve in that role if called upon to do so.

Signed: ______________________________ Date: ____________

(Optional) I affirm that I have given or will give a copy of my Advance Directive to my Doctor or Clinician.

Signed: ______________________________ Date: ____________

Acknowledgement of Witnesses — I affirm that the Principal appears to understand the nature of an Advance Directive and to be free from duress or undue influence.

Signed: ______________________________ Date: ____________

Print Name: ______________________________

Signed: ______________________________ Date: ____________

Print Name: ______________________________

Acknowledgement by the person who explained this Advance Directive if the principal is a current patient or resident in a *hospital, or other health care facility.*

I affirm that:

- the maker of this Advance Directive is a current patient or resident in a hospital, nursing home or residential care facility,
- I am an ombudsman, recognized member of the clergy, an attorney licensed to practice in Vermont, or a probate court or hospital designee, and
- I have explained the nature and effect of the Advance Directive to the Principal and it appears that the Principal is willingly and voluntarily executing it.

Name: ____________________ Title/position: ____________________

Address: ______________________________

Tel.: ____________________ Date: ____________________

Important!

Please list below the people and locations that will have a copy of this document:

_____**Vermont Advance Directive Registry** (anticipated available by mid- 2007)

____ **Health care agent(s)**

____ **Alternate health care agent**

_____ **Family members:** (List by name all who have copies)

Name ____________________

Address ____________________

Name ____________________

Address ____________________

Name ____________________

Address ____________________

Name ____________________

Address ____________________

Name ____________________

Address ____________________

_____ MD (Name)____________________Address____________________

_____ Hospital (s) (Names)____________________

_____ Other individuals or locations:

____

____

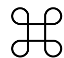
____

____

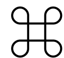
____

____

Triage Health Estate Planning Toolkit



Part III: Your State’s Estate Planning Forms



Physician Orders for Life Sustaining Treatment (POLST)

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

VERMONT
DEPARTMENT OF HEALTH

INSTRUCTIONS FOR CLINICIANS
COMPLETING VERMONT DNR/COLST FORM
(DO NOT RESUSCITATE ORDER/CLINICIAN ORDERS FOR LIFE SUSTAINING TREATMENT)

Completing DNR/COLST

- The DNR/COLST form must be completed and signed by a health care clinician based on patient preferences and medical indications. A clinician is defined as a medical doctor, osteopathic physician, advance practice registered nurse or physician assistant. 18 V.S.A. § 9701(5). Verbal orders are acceptable with follow-up signature by the clinician in accordance with facility/community policy.
- Photocopies and Faxes of signed COLST forms are legal and valid; use of original is encouraged.

Special requirements for completing the DNR section of COLST (18 V.S.A. §§9708, 9709)

- A DNR order may be written on the basis of either informed consent or futility. Complete section A-2 for informed consent; Section A-3 for futility.
- An order based on informed consent must include the name of the patient, agent, guardian, or other individual giving informed consent. Beginning January 2018, the name of the patient, agent, guardian, or surrogate.
- An order based on futility must include a certification by the clinician and a second clinician that resuscitation would not prevent the imminent death of the patient, should the patient experience cardiopulmonary arrest.
- If patient is in a health care facility, the clinician must certify that the requirements of the facility's DNR protocol as required by 18 V.S.A. § 9709 have been met
- The clinician shall authorize the issuance of a DNR identification to the patient
- Clinician must certify that clinician has consulted or made an attempt to consult with the patient, and the patient's agent or guardian.

Using DNR Order - Section A CPR/DNR - 18 V.S.A. § 9708(i) and (l)

- A DNR Order (Section A of the DNR/COLST form) only precludes efforts to resuscitate in the event of cardiopulmonary arrest and does not affect other therapeutic interventions that may be appropriate for the patient. (Sections B through H of the COLST Form address other interventions.)
- Health care professionals, health care facilities, and residential care facilities must honor a DNR order or a DNR Identification unless the professional or facility believes in good faith, after consultation with the patient, agent or guardian, where possible and appropriate
    - that the patient wishes to have the DNR Order revoked, or
    - that the patient with the DNR identification or order is not the individual for whom the DNR order was issued.

  Documentation of basis for belief in medical record is required.

Using COLST (Sections B through H)

- Any section of COLST not completed indicates that the COLST order does not address that topic. It may be addressed in a patient's advance directive, or in other parts of the medical record.
- Oral fluids and nutrition must always be offered if medically feasible.
- When comfort cannot be achieved in the current setting, the person, including someone with "comfort measures only", may be transferred to a setting able to provide comfort.
- Treatment of dehydration is a measure that may prolong life. For a patient who desires IV fluids the order should indicate "Limited Interventions" or Full Treatment."
- A patient with or without capacity, or another person authorized to provide consent, may revoke the COLST order at any time and request alternative treatment. Exceptions may apply. See, 18 V.S.A. § 9707(h) or 18 V.S.A. § 9707(g).
- Photocopies and faxes of signed DNR/COLST forms are legal and valid; use of original is encouraged.

Documenting Clinician's Verbal Order (Sections A6 & H)

To document a clinician's verbal order for a DNR/COLST:

- The patient's nurse or social worker must print the clinician's name in **Section A6 for DNR** and/or **Section H for COLST** and write "Verbal Order" on the clinician signature line.
- The nurse or social worker documenting the verbal order must also sign and date the form.
- A duplicate DNR/COLST must be completed and sent to the clinician for an original signature.
- At the earliest convenience, the order with the original signature must be returned to the patient to replace the previously documented verbal order.

Reviewing DNR/COLST

This form should be reviewed periodically and a new form completed if necessary when:

1. The patient is transferred from one care setting or care level to another, or
2. There is a substantial change in the patient's health status, or
3. The patient's treatment preferences change, or
4. At least annually, but more frequently in residential or inpatient settings.

Voiding DNR/COLST

To void this form or a part of it, draw a line through each page or section to be voided and write "VOID" in large letters.

VERMONT DEPARTMENT OF HEALTH

VERMONT DNR/COLST - Clinician orders for DNR/CPR & Other Life Sustaining Treatment

PATIENT:____BIRTHDATE:______________
LAST NAME FIRST NAME MIDDLE INITIAL

SECTION A: Cardiopulmonary Resuscitation: Follow these orders when patient is unresponsive & has NO pulse

○ **NO CPR: Do Not Attempt Resuscitation (DNR)**
(Allow Natural Death)

○ **YES CPR: Attempt Resuscitation,** including chest compressions, intubation, mechanical ventilation, defibrillation and transfer to hospital.

Basis for DNR order: informed consent OR medical non-benefit (Choose one)

○ **Informed Consent obtained from:**

____
Name of Person Giving Informed Consent (Can be Patient)

____
Relationship to Patient (Write "self" if Patient)
(agent, guardian or surrogate)

____
Signature (if available; not required)
☐ Verbal Consent

OR

○ **This DNR order is written on the basis of medical non-benefit (futility). Required if no consent.**

I have determined that resuscitation would not prevent the imminent death of this patient should the patient experience cardiopulmonary arrest. Another clinician has also so determined:

____
Name of Other Clinician Making this Determination (Print here)

____
Signature of Other Clinician Date

SECTION B: Intubation and Ventilation: Follow these orders in the event of respiratory distress & HAS a pulse

Instructions for Intubation and Ventilation: **(Invasive: place a tube down the patients throat and connect a breathing machine)**

Mark one circle →

○ NO, do not intubate and ventilate **(DO NOT check if you checked "YES CPR" in section A)**

○ TRIAL COURSE, of intubation and ventilation treatment

○ YES, intubate and ventilate

SECTION C: Medical Intervention Guidelines

○ **Focus on Sustaining Life.** Use intubation, advanced airway interventions, and mechanical ventilation as indicated. *Transfer to hospital and/or intensive care unit if indicated.* All patients will receive comfort-focused treatments.
Treatment Plan: Full treatment including life support measures in the intensive care unit.

○ **Avoid Invasive Interventions.** Use medical treatment, antibiotics, IV fluids and cardiac monitor as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. high flow, CPAP, BiPAP). *Transfer to hospital if indicated.* Generally avoid intensive level of care (e.g. ICU). All patients will receive comfort-focused treatments.
Treatment Plan: Provide basic medical treatments aimed at treating new or reversible illness.

○ **Comfort-Focused Treatment (Allow Natural Death).** 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: Maximize comfort through symptom management.

Facility DNR Protocol Requirement (required for patients in health care or residential care facilities, skip if patient is not in a facility)

☐ This patient is in a health care facility or a residential care facility.

Name of Facility: ______________________________

The requirements of the facility's DNR protocol have been met. __________ (Initial here if protocol requirements have been met.)

SIGNATURE OF CLINICIAN for section A, B & C (signature authorizes DNR identification)

Clinician (Print Name):____________________ Signature:____________________ Date __________

PATIENT:____BIRTHDATE:____________________
LAST NAME FIRST NAME MIDDLE INITIAL

SECTION D: Orders For Other Life Sustaining Treatments

Artificially Administered Nutrition and Hydration

Nutrition (Mark one circle)	○ NO, do not administer artificial nutrition	○ TRIAL COURSE, of short-term artificial nutrition. No long term.	○ YES, administer artificial nutrition	○ Did not discuss
Hydration (Mark one circle)	○ NO, do not administer artificial hydration	○ TRIAL COURSE, of short-term artificial hydration	○ YES, administer artificial hydration	○ Did not discuss
Antibiotics (Mark one circle)	○ NO, do not use antibiotics	○ Determine use or limitation of antibiotics when infection occurs, with comfort as goal.	○ YES, administer antibiotics (if indicated)	○ Did not discuss

Other preferences (e.g. dying at home, awareness/level of consciousness, living independently, etc.) and treatment goals specific to the patient's medical condition and care needs (e.g. blood products, dialysis, etc.).

____

____

Informed Consent for orders for other life sustaining treatment (section D) has been obtained from:

______________________ Name of Person Giving Informed Consent (Can be Patient)

______________________ Relationship to Patient (Write "self" if Patient)

______________________ Signature (if available; not required)

☐ Verbal Consent

SIGNATURE OF CLINICIAN for section D

Clinician (Print Name):______________________ **Signature:**______________________**Date** __________

SECTION E: Additional Information

○ Health Care Agent/Advance Directive

______________________ Name of Health Care Agent(s) / phone

○ Guardianship Order

______________________ Name of Guardian / phone

○ Surrogate

______________________ Name of Surrogate / phone

Note: This section CANNOT be used to appoint the health care agent or guardian. Only check if there is existing documentation of medical decision-makers in an advance directive or court order for guardianship. Guardians require additional oversight for permission to consent (emergency exceptions apply).

○ Patient enrolled in hospice: Name of Hospice Agency ______________________ Phone/Contact ______________________

SECTION F: REVIEWS

Date	Reviewer	Location	Outcome
			○ No Change ○ New form completed ○ Form Voided

Instructions For Clinicians Completing This Form

Completing DNR/COLST:

- Must be completed and signed by a health care clinician (MD, DO, APRN, or PA) based on patient's medical condition, goals and values.
- Verbal orders are acceptable with follow-up signature by the clinician in accordance with facility/agency policy.
- Photocopies and faxes of signed DNR/COLST order are legal and valid.
- By signing, clinician is certifying that they have consulted or made an attempt to consult with the patient, the patient's agent, guardian or surrogate.

Documenting Clinician's Verbal Order

- The patient's nurse or social worker must print the clinician's name and write "Verbal Order" on the clinician signature line.
- The nurse or social worker documenting the verbal order must also sign and date the form.
- A duplicate DNR/COLST must be completed and sent to the clinician for an original signature.
- At the earliest convenience, the order with the original signature must be returned to the patient to replace the previously documented verbal order.

VERMONT
DEPARTMENT OF HEALTH

INSTRUCTIONS FOR CLINICIANS
COMPLETING VERMONT DNR/COLST FORM
(DO NOT RESUSCITATE ORDER/CLINICIAN ORDERS FOR LIFE SUSTAINING TREATMENT)

Completing DNR/COLST

- The DNR/COLST form must be completed and signed by a health care clinician based on patient preferences and medical indications. A clinician is defined as a medical doctor, osteopathic physician, advance practice registered nurse or physician assistant. 18 V.S.A. § 9701(5).
  - A "clinician" also includes a duly licensed medical doctor, osteopathic physician, advanced practice registered nurse or nurse practitioner, or physician assistant who treated the patient outside Vermont and held a valid license to practice in the state in which the patient was located at the time the DNR/COLST was issued. (18 V.S.A § 9708).
- Verbal orders are acceptable with follow-up signature by the clinician. See Documenting Clinician's Verbal Order (sections A & D) below.
- Photocopies and Faxes of signed COLST forms are legal and valid.
- Prior orders completed on previously approved Vermont DNR/COLST forms remain legal and valid and shall be honored.

Special requirements for completing the DNR section of COLST (18 V.S.A. §§9708, 9709)

- A DNR order may be written on the basis of either informed consent or futility. Indicate the basis for the order in Section A.
- An order based on informed consent must include the name of the patient, agent, guardian, or other individual giving informed consent.
- An order based on futility must include a certification by the clinician and a second clinician that resuscitation would not prevent the imminent death of the patient, should the patient experience cardiopulmonary arrest.
- If patient is in a health care facility, the clinician must certify that the requirements of the facility's DNR protocol as required by 18 V.S.A. § 9709 have been met.
- Clinician signature on this form serves as the issuance of a DNR Identification.
- Clinician signature certifies that the clinician has consulted or made an attempt to consult with the patient, and the patient's agent or guardian if there is an appointed agent or guardian.

Using DNR Order - Section A CPR/DNR - 18 V.S.A. § 9708(i) and (l)

- A DNR Order (Section A of the DNR/COLST form) only precludes efforts to resuscitate in the event of cardiopulmonary arrest and does not affect other therapeutic interventions that may be appropriate for the patient. (Sections B through D of the COLST Form address other interventions.)
- Health care professionals, health care facilities, and residential care facilities must honor a DNR order or a DNR Identification unless the professional or facility believes in good faith, after consultation with the patient, agent or guardian, where possible and appropriate:
  - the patient wishes to have the DNR/COLST order revoked; or
  - the patient with the DNR identification or order is not the individual for whom the DNR order was issued; and
  - documents the basis for the good faith belief in the patient's medical record.

Using COLST (Sections B through D)

- Any sections not completed indicate that the COLST order does not address that topic. It may be addressed in a patient's advance directive, or in other parts of the medical record.
- When comfort cannot be achieved in the current setting, the person, including someone with "comfort-focused treatment", may be transferred to a setting able to provide comfort.
- A patient with or without capacity, or another person authorized to provide consent, may revoke the COLST order at any time and request alternative treatment. Exceptions may apply. See, 18 V.S.A. § 9707(g) or 18 V.S.A. § 9707(h).
- Photocopies and faxes of signed DNR/COLST forms are legal and valid.

Documenting Clinician's Verbal Order (Sections A & D)
To document a clinician's verbal order for a DNR/COLST:

- The patient's nurse or social worker must print the clinician's name in **Section A for DNR** and/or **Section D for COLST** and write "Verbal Order" on the clinician signature line.
- The nurse or social worker documenting the verbal order must also sign and date the form.
- A duplicate DNR/COLST must be completed and sent to the clinician for an original signature.
- At the earliest convenience, the order with the original signature must be returned to the patient to replace the previously documented verbal order.

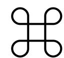
Reviewing DNR/COLST
This form should be reviewed periodically and a new form completed if necessary when:

1. The patient is transferred from one care setting or care level to another, or
2. There is a substantial change in the patient's health status, or
3. The patient's treatment preferences change, or
4. At least annually, but more frequently in residential or inpatient settings.

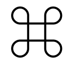
Voiding DNR/COLST

To void this form or a part of it, draw a line through each page or section to be voided and write "VOID" in large letters.

Triage Health Estate Planning Toolkit



Part III: Your State's Estate Planning Forms



HIPAA Authorization Form

Disclaimer: This toolkit is intended to provide general information on the topics presented. It is provided with the understanding that Triage Cancer is not engaged in rendering any legal, medical, or professional services by its publication or distribution. Although this content was reviewed by a professional, it should not be used as a substitute for professional services.

Sample HIPAA Right of Access Form for Family Member/Friend

I, _________________________________, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: *Relationship:*

______________________________ _____________________________________

Contact information: ____

____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

- ☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**
- ☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV and AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (please specify):
    ____
    ____

Form of Disclosure (unless another format is mutually agreed upon between my provider and designee):

- ☐ An electronic record or access through an online portal
- ☐ Hard copy

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event:____

unless I revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

____ _____________________
Name of the Individual Giving this Authorization Date of birth

____ _____________________
Signature of the Individual Giving this Authorization Date

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524