FREE VITAL MEDICAL INFORMATION FILE
INFORMATION AND INSTRUCTIONS

WHAT IS IT? The Vital Medical Information File is a Putnam County program designed to ensure that all citizens receive prompt and appropriate medical care in accordance with their wishes. When fully implemented, the Vital Medical Information File ensures that all of a person's important medical information is in one place and is easily accessible to you or a caregiver when going to the doctor, and to EMT's arriving on an emergency call. By creating a personal Vital Medical Information File, citizens are empowered to be their own healthcare advocates, even should they become unable to speak for themselves.

WHO IS IT FOR? The Vital Medical Information File is appropriate for all adults, but we are focusing on getting them in the hands of persons aged 60+ and persons living with serious, chronic illness.

HOW DOES IT WORK? Persons choosing to use the Vital Medical Information File will receive a red vinyl envelope with a strong magnet on the back designed to keep the envelope securely on the outside of your home's refrigerator. This envelope is designed to hold all your important medical information in one accessible location.

WHAT SHOULD I INCLUDE IN MY VITAL MEDICAL INFORMATION FILE?
All adults should include the following in their Vital Medical Information File:

- The completed Vital Medical Information Form identifying medications, blood type, allergies, health conditions, recent surgeries, etc.
- Copy of current medical insurance cards and photo ID card.
- Copy of legally signed healthcare representative documentation.
- Copy of legally signed living will documentation.

If applicable, your Vital Medical Information File should also include the following:

- Copy of Veteran cards.
- Copy of implanted medical device information, if applicable, such as pacemaker, heart stents, prostheses, etc.
- Indiana Out of Hospital Do Not Resuscitate form - *for persons who are seriously ill and/or frail, and must be signed by a physician, NP, or PA.*
- Indiana Physician's Order for Scope of Treatment (POST) form - *for persons who are seriously ill and/or frail, and must be signed by a physician, NP, or PA.*

Please see other side for instructions to use your FREE VITAL MEDICAL INFORMATION FILE.

Putnam County HOSPICE and PALLIATIVE CARE ASSOCIATION
SPEAKING UP FOR YOUR CARE

PUTNAM COUNTY HOSPICE AND PALLIATIVE CARE ASSOCIATION
1542 South Bloomington Street
Greencastle, IN 46135
www.pchpca.org
contact.us@pchpca.org

Instructions for Using the Vital Medical Information File

1. Write your name on the outside of the Vital Medical Information File red envelope in permanent marker.
2. Fill out the Vital Medical Information Form. Print and be sure the information is accurate and legible. Include current date.
   a. Use a sharp pencil to allow you to make updates in the future.
   b. Make a copy of the completed form and put it in your Vital Medical Information File red envelope.
   c. Put original in a fire-safe location.
   d. Make plans to update the Vital Medical Information Form at least annually when you have your annual wellness physical.
3. Complete advance directive forms as appropriate and desired. The Indiana Advance Directive Form provided in the File helps you name healthcare representatives and make your own healthcare choices (i.e., living will). The Indiana Advance Directive Form may also be completed online and then printed at https://prepareforyourcare.org/en/welcome. The Out of Hospital Do Not Resuscitate form and the Physicians Order for Scope of Treatment (POST) form (on pink paper) are for seriously ill and/or frail individuals and must be signed by a physician, physicians assistant or nurse practitioner.
   a. Obtain required signatures on forms.
   b. Make copies of signed advance directives and give them to loved ones, caregivers, and healthcare providers.
   c. Put copies of signed advance directive forms in the red envelope.
   d. Put originals in a fire-safe location.
   e. Talk with your healthcare representatives, healthcare providers, and loved ones about your advance directives and your wishes.
4. Put copies of ID card, health insurance cards, including VA cards if applicable, in the Vital Medical Information File red envelope.
5. Put copies of identification cards for pacemaker, prostheses, implants, heart stents, etc. in Vital Medical Information File red envelope.
6. Hang the Vital Medical Information File red envelope on the outside of your refrigerator.
7. Fill out the "I HAVE AN ADVANCE DIRECTIVE" wallet card and keep it in your wallet.
8. Put decal on outside door to alert emergency personnel that you have a Vital Medical Information File on your refrigerator.
9. Notify family members, caregivers, and others whom you trust that you have a Vital Medical Information File on your refrigerator.
10. Take the red envelope with you when you visit your doctor. Keep medical information up-to-date. Whenever there is a change in your medications or dosages, be sure to change it on your Vital Medical Information Form and re-date the card.

Where to go for help

If you have questions or need assistance completing your Vital Medical Information File, contact the Putnam County Hospice and Palliative Care Association at contact.us@pchpca.org or 765.301.7614.

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www.pchpca.org
contact.us@pchpca.org

VITAL MEDICAL INFORMATION FORM

Keep information up to date. Use pencil for ease when updating. Email contact.us@pchpca.org for additional forms.

MEDICAL INFORMATION REVIEWED: MONTH _____ YEAR _____

NAME: _____

ADDRESS: _____

GENDER: M / F **DATE OF BIRTH:** _____ **BLOOD TYPE:** _____

VETERAN: YES / NO **BRANCH OF SERVICE:** ARMY / NAVY / AIR FORCE / MARINES / COAST GUARD

RELIGION: _____

PRIMARY CARE PROVIDER: _____ **PRIMARY CARE PROVIDER PHONE:** _____

PRIMARY CARE PROVIDER CITY/STATE: _____

PREFERRED HOSPITAL: _____

PHARMACY: _____ **PHARMACY PHONE:** _____

EMERGENCY CONTACTS

HEALTHCARE REPRESENTATIVE NAME: _____ **PHONE:** _____

ADDRESS: _____

EMERGENCY NAME: _____ **RELATION:** _____

ADDRESS: _____ **PHONE:** _____

ALT. EMERGENCY NAME: _____ **RELATION:** _____

ADDRESS: _____ **PHONE:** _____

I HAVE THE FOLLOWING ADVANCE DIRECTIVES (check and circle all that apply)

☐ **HEALTHCARE REPRESENTATIVE:** LOCATED IN THIS FILE / LOCATED AT : _____

☐ **LIVING WILL:** LOCATED IN THIS FILE / LOCATED AT: _____

☐ **OUT OF HOSPITAL DO NOT RESUSCITATE ORDER:** LOCATED IN THIS FILE / LOCATED AT: _____

☐ **PHYSICIANS ORDER FOR SCOPE OF TREATMENTS (POST):** LOCATED IN THIS FILE / LOCATED AT: _____

☐ **ORGAN DONOR:** LOCATED IN THIS FILE / ON MY DRIVERS LICENSE / LOCATED AT: _____

VACCINATION HISTORY (check and include most recent date of all that apply)

☐ **INFLUENZA** _____ ☐ **PNEUMONIA (Pneumonalcoccal 23)** _____ ☐ **PNEUMONIA (Prevnar 13)** _____

☐ **COVID** _____ ☐ **SHINGLES** _____ ☐ **TETANUS** _____ **OTHER** _____

CONDITIONS AND INFORMATION NOT IDENTIFIED ON OTHER SIDE

_____

_____

_____

CURRENT MEDICATIONS

MEDICATION	DOSE	FREQUENCY	MEDICATION	DOSE	FREQUENCY

HISTORY OF SURGERIES

SURGERY / SURGEON'S NAME	DATE/YEAR	SURGERY / SURGEON'S NAME	DATE/YEAR

MEDICAL CONDITIONS (CHECK ALL THAT APPLY)

Include additional information on the bottom of the first page.

- ☐ Addiction / Abuse / Alcoholism
- ☐ Adrenal insufficiency
- ☐ Anemia _____
- ☐ Aneurism _____
- ☐ Artificial limb _____
- ☐ Artificial joint _____
- ☐ Asthma _____
- ☐ Autoimmune disease _____
- ☐ Bleeding / clotting disorder
- ☐ Blood Pressure: High/Low
- ☐ Cancer _____
- ☐ Cholesterol—high
- ☐ Congestive Heart Failure (CHF)
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Dementia / Alzheimer's
- ☐ Diabetes: Type 1 / Type 2
- ☐ Hearing impaired_____
- ☐ Heart—Abnormal EKG
- ☐ Heart—Atrial Fibrillation
- ☐ Heart—Angina
- ☐ Heart attack history _____
- ☐ Heart disease _____
- ☐ Heart Pacemaker
- ☐ Heart valve prosthesis
- ☐ Heart stent(s)
- ☐ Hepatitis—Type _____
- ☐ Hypoglycemia
- ☐ Kidney disease / failure / dialysis
- ☐ Liver disease _____
- ☐ Lung disease _____
- ☐ Mental Illness _____
- ☐ Metal plates / pins, etc. _____
- ☐ Myasthenia Gravis
- ☐ Seizure Disorder
- ☐ Sickle Cell Anemia
- ☐ Stroke _____
- ☐ Thyroid disease: Hyper / Hypo
- ☐ Tuberculosis
- ☐ Vision Impaired _____
- ☐ Other _____
- ☐ Other _____
- ☐ Other _____

MEDICAL INSURANCE INFORMATION

Include copies of most recent cards in file.

_____

Medical Insurance Company Name 1

Policy #_____

_____

Medical Insurance Company Name 2

Policy #_____

Medicaid #: _____

Medicare # _____

Veterans Admin # _____

Last four SSN # _____

ALLERGIES (CHECK ALL THAT APPLY)

- ☐ Aspirin
- ☐ Barbiturate
- ☐ Codeine
- ☐ Demerol
- ☐ Horse Serum
- ☐ Insect Stings
- ☐ Latex
- ☐ Lidocaine
- ☐ Novocaine
- ☐ Opiods
- ☐ Penicillin
- ☐ Sulfa
- ☐ Tetracycline
- ☐ X-Ray Dyes
- ☐ Environmental_____
- ☐ Other _____

Indiana Advance Health Care Directive

This form lets you have a say about how you want to be cared for if you cannot speak for yourself.

This form has 3 parts:

Part 1 **Choose your health care representatives, Page 3**

A health care representative is a person who can make health care decisions for you if you are not able to make them yourself.

You can choose one or more health care representatives to be your advocate.

Sometimes, they are also called a medical decision maker, surrogate, health care power of attorney, agent, or proxy.

Part 2 **Make your own health care choices, Page 7**

This form lets you choose the kind of health care you want. This way, those who care for you will not have to guess what you want if you are not able to tell them yourself.

Part 3 **Sign the form, Page 13**

The form must be signed before it can be used.

You can fill out Part 1, Part 2, or both.

Fill out only the parts you want. Always sign the form in Part 3.

2 witnesses need to sign on Page 14, or a notarial officer on Page 15.

Your Name

Developed by PREPARE™ for your care

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This is a legal form that lets you have a voice in your health care.

It will let your family, friends, and medical providers know how you want to be cared for if you cannot speak for yourself.

What should I do with this form?

- Please share this form with your health care representatives, family, friends, and medical providers.
- Please make sure copies of this form are placed in your medical record at all the places you get care.

What if I have questions about the form?

- It is OK to skip any part of this form if you have questions or do not want to answer.
- Ask your doctors, nurses, social workers, family, or friends to help.
- Lawyers can help too. This form does not give legal advice.

What if I want to make health care choices that are not on this form?

- On Page 12, you can write down anything else that is important to you.

When should I fill out this form again?

- If you change your mind about your health care choices
- If your health changes
- If you want to change your health care representatives
- If your spouse is your health care representative, and you divorce, that person will no longer be your health care representative.

Give the new form to your health care representatives and medical providers.

Destroy old forms to show they are no longer your wishes.

Share this form and your choices with your family, friends, and medical providers.

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Part 1 Choose your health care representatives

Choose one or more health care representatives. They can make health care decisions for you if you are not able to make them yourself.

A good health care representative is a family member or friend who:

- is 18 years of age or older
- can talk to you about your wishes
- can be there for you when you need them
- you trust to follow your wishes and do what is best for you
- you trust to know your medical information
- is not afraid to ask doctors questions and speak up about your wishes

What will happen if I do not choose a health care representative?

If you are not able to make your own decisions, your doctors will turn to adult family or friends (listed in order in Indiana law) or a judge to make decisions for you. **This person may not know what you want.**

If you are not able, your health care representatives can choose these things for you:

- doctors, nurses, social workers, caregivers
- hospitals, clinics, nursing homes
- medications, tests, or treatments
- who can look at your medical information
- what happens to your body and organs after you die
- who can look at your financial information to apply for benefits that would pay for your health care

End of life decisions your health care representatives can make:

- call in a religious or spiritual leader
- decide if you die at home or in the hospital
- decide about autopsy or organ donation
- decide about burial or cremation

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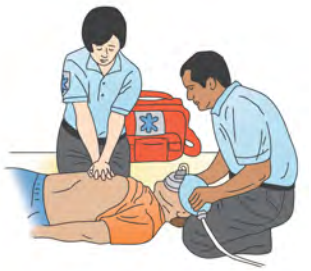
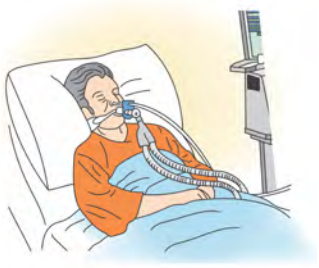
Here are more decisions your health care representatives can make:

Start or stop life support or medical treatments, such as:

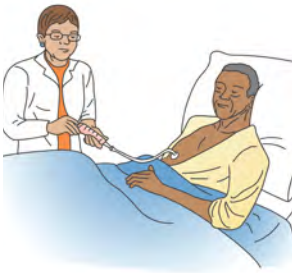


- **CPR or cardiopulmonary resuscitation**
  cardio = heart • pulmonary = lungs • resuscitation = try to bring back

  This may involve:
  - pressing hard on your chest to try to keep your blood pumping
  - electrical shocks to try to jump start your heart
  - medicines in your veins



- **Breathing machine or ventilator**
  The machine pumps air into your lungs and tries to breathe for you. You are not able to talk when you are on the machine.
- **Dialysis**
  A machine that tries to clean your blood if your kidneys stop working.
- **Feeding Tube**
  A tube used to try to feed you if you cannot swallow. The tube can be placed through your nose down into your throat and stomach. It can also be placed by surgery into your stomach.



- **Blood and water transfusions (IV)**
  To put blood and water into your body.
- **Surgery**
- **Medicines**
- **Mental health treatment**

By signing this form, you allow your health care representatives to:

- agree to, refuse, or withdraw any life support or medical treatment if you are not able to speak for yourself
- decide what happens to your body after you die, such as organ donation, autopsy, and funeral plans

If there are decisions you do not want them to make, write them here:

Your Name

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When can my health care representatives make decisions for me?

- ☐ ONLY after I am not able to make my own decisions
- ☐ NOW, right after I sign this form. If I am able to choose, I can always say no to their decision.

If you want, you can write why you feel this way.

Write the name of one or more health care representatives.

I want these people to make my medical decisions if I am not able to make my own:

#1:

first name _____ last name _____

phone #1 _____ email or phone #2 _____ relationship _____ state _____

#2:

first name _____ last name _____

phone #1 _____ email or phone #2 _____ relationship _____ state _____

If you chose more than one health care representative:

Do you have a main health care representative?

- ☐ I want my #1 health care representative to make all the decisions. The #2 health care representative is only a back up.
- ☐ I want my #1 and #2 health care representatives to make decisions together.

How do you want your health care representative to work together?

- ☐ They must always talk and make decisions together and agree.
- ☐ Whoever your doctor can reach first can decide.

Sometimes health care representatives do not agree. If they cannot agree and it is an emergency, your doctor may make the final decision. Your doctor will only decide after checking with another medical provider.

Your Name _____

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Why did you choose your health care representatives?

If you want, you can write why you chose your #1 and #2 health care representatives.

Write down anyone you would NOT want to help make medical decisions for you.

How strictly do you want your health care representatives to follow the wishes on this form if you are not able to speak for yourself?

Flexibility allows your health care representatives to change your prior decisions if doctors think something else is better for you at that time.

Prior decisions may be wishes you wrote down or talked about with your health care representatives. You can write your wishes in Part 2 of this form.

Check the one choice you most agree with.

- ☐ **Total Flexibility:** It is OK for my health care representatives to change any of my medical decisions if my doctors think it is best for me at that time.
- ◯ **Some Flexibility:** It is OK for my health care representatives to change some of my decisions if the doctors think it is best. But, these wishes I NEVER want changed:
- ◯ **No Flexibility:** I want my health care representatives to follow my medical wishes exactly. It is NOT OK to change my decisions, even if the doctors recommend it.

If you want, you can write why you feel this way.

To make your own health care choices, go to Part 2 on Page 7. If you are done, you must sign this form on Page 13.

Please share your wishes with your family, friends, and medical providers.

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Part 2 Make your own health care choices

Fill out only the questions you want.

How do you prefer to make medical decisions?

Some people prefer to make their own medical decisions. Some people prefer input from others (family, friends, and medical providers) before they make a decision. And, some people prefer other people make decisions for them.

Please note: Medical providers cannot make decisions for you. The only time they can is if it is an emergency and your health care representatives cannot agree.

How do you prefer to make medical decisions?

- ☐ I prefer to make medical decisions on my own without input from others.
- ☐ I prefer to make medical decisions only after input from others.
- ☐ I prefer to have other people make medical decisions for me.

If you want, you can write why you feel this way, and who you want input from.

What matters most in life? Quality of life differs for each person.

What is most important in your life? Check as many as you want.

- ☐ Your family or friends _____
- ☐ Your pets _____
- ☐ Hobbies, such as gardening, hiking, and cooking
  Your hobbies _____
- ☐ Working or volunteering _____
- ☐ Caring for yourself and being independent
- ☐ Not being a burden on your family
- ☐ Religion or spirituality: Your religion _____
- ☐ Something else _____

What brings your life joy? What are you most looking forward to in life?

Your Name

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What matters most for your medical care? This differs for each person.

For some people, the main goal is to be kept alive as long as possible even if:

- They have to be kept alive on machines and are suffering
- They are too sick to talk to their family and friends

For other people, the main goal is to focus on quality of life and being comfortable.

- These people would prefer a natural death, and not be kept alive on machines

Other people are somewhere in between. **What is important to you?**

Your goals may differ today in your current health than at the end of life.

TODAY, IN YOUR CURRENT HEALTH

Check one choice along this line to show how you feel today, in your current health.

My main goal is to live as long as possible, no matter what.

Equally important

My main goal is to focus on quality of life and being comfortable.

If you want, you can write why you feel this way.

AT THE END OF LIFE

Check one choice along this line to show how you would feel if you were so sick that you may die soon.

My main goal is to live as long as possible, no matter what.

Equally important

My main goal is to focus on quality of life and being comfortable.

If you want, you can write why you feel this way.

Your Name

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Quality of life differs for each person at the end of life. What would be most important to you?

AT THE END OF LIFE

Some people are willing to live through a lot for a chance of living longer.

Other people know that certain things would be very hard on their quality of life.

- Those things may make them want to focus on comfort rather than trying to live as long as possible.

At the end of life, which of these things would be very hard on your quality of life?
Check as many as you want.

- ☐ Being in a coma and not able to wake up or talk to my family and friends
- ☐ Not being able to live without being hooked up to machines
- ☐ Not being able to think for myself, such as severe dementia
- ☐ Not being able to feed, bathe, or take care of myself
- ☐ Not being able to live on my own, such as in a nursing home
- ☐ Having constant, severe pain or discomfort
- ☐ Something else _____

- ☐ **OR**, I am willing to live through all of these things for a chance of living longer.

If you want, you can write why you feel this way.

What experiences have you had with serious illness or with someone close to you who was very sick or dying?

- If you want, you can write down what went well or did not go well, and why.

If you were dying, where would you want to be?

☐ at home ☐ in the hospital ☐ either ☐ I am not sure

What else would be important, such as food, music, pets, or people you want around you?

Your Name

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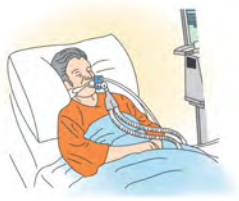
How do you balance quality of life with medical care?

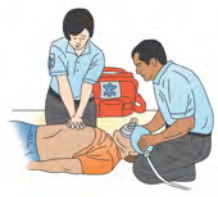
Sometimes illness and the treatments used to try to help people live longer can cause pain, side effects, and the inability to care for yourself.

Please read this whole page before making a choice.

AT THE END OF LIFE, some people are willing to live through a lot for a chance of living longer. Other people know that certain things would be very hard on their quality of life.

Life support treatment can be CPR, a breathing machine, feeding tubes, dialysis, or transfusions.





Check the one choice you most agree with.

If you were so sick that you may die soon, what would you prefer?

- ☐ **Try all life support treatments** that my doctors think might help. I want to **stay on life support** treatments even if there is little hope of getting better or living a life I value.

- ◯ Do a **trial of life support treatments** that my doctors think might help. But, I **DO NOT want to stay on life support** treatments if the treatments do not work and there is little hope of getting better or living a life I value.

- ◯ **I do not want life support treatments**, and I want to focus on being comfortable. I prefer to have a **natural death**.

What else should your medical providers and health care representatives know about this choice? Or, why did you choose this option?

Your Name

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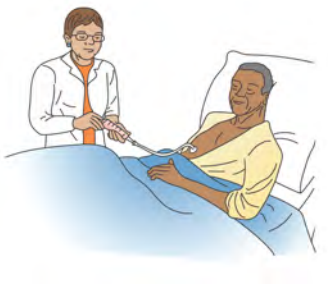
Artificial food and water:

Check the one choice you most agree with.

If you were so sick that you may die soon, what would you prefer?

- ☐ I **want** food and water by feeding tubes and transfusions (IV) even if there is little hope of getting better or living a life I value.
- ◯ Do a **trial** of food and water by feeding tubes and transfusions (IV) if my doctors think they might help. But, I **want to stop them** if the treatments do not work and there is little hope of getting better or living a life I value.

- ◯ I **do not want** food and water by feeding tubes and transfusions (IV) if there is little hope of getting better or living a life I value.



- ◯ I want my **health care representatives to decide** about food and water by feeding tubes and transfusions (IV) for me.

If I am not able to share my wishes, I want the wishes on this form to be honored.

I fully understand what these options mean.

What else should your medical providers and health care representatives know about this choice? Or, why did you choose this option?

Your Name

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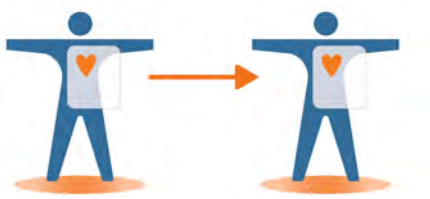
Your health care representatives may be asked about organ donation and autopsy after you die. You can tell your health care representatives what you want below.

ORGAN DONATION

Some people decide to donate their organs or body parts. What do you prefer?



- ☐ I **want** to donate my organs or body parts.

  Which organ or body part do you want to donate?

  - ☐ Any organ or body part
  - ◯ Only _____

- ◯ I **do not** want to donate my organs or body parts.

What else should your medical providers and health care representatives know about donating your organs or body parts?

AUTOPSY

An autopsy can be done after death to find out why someone died. It is done by surgery. It can take a few days.

- ☐ I **want** an autopsy.
- ◯ I **do not** want an autopsy.
- ◯ I **only** want an autopsy if there are questions about my death.

FUNERAL OR BURIAL WISHES

What should your medical providers and health care representatives know about how you want your body to be treated after you die, and your funeral or burial wishes?

- Do you have religious or spiritual wishes?
- Do you have funeral or burial wishes?

Your Name

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What else should your medical providers and health care representatives know about you and your choices for medical care?

OPTIONAL: How do you prefer to get medical information?

Some people may want to know all of their medical information. Other people may not.

If you had a serious illness, would you want your doctors and medical providers to tell you how sick you are or how long you may have to live?

- ☐ Yes, I would want to know this information.
- ◯ No, I would not want to know. Please talk with my health care representatives instead.

If you want, you can write why you feel this way.

* Talk to your medical providers so they know how you want to get information.

Your Name

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Part 3 Sign the form

Before this form can be used, you must:

1. **Sign this form**
2. Have 2 people or a notarial officer witness that you signed this form. You and your witnesses must be 18 years of age or older.

   Your witnesses:

   - cannot be your health care representatives
   - cannot help you sign your name on this form
   - cannot both be related to you, but one witness can be related to you

You and your witnesses or notarial officer must sign at the same time.

You have 3 options to sign this form with your witnesses.

A notarial officer can do the first 2 options, but not the 3rd option.

Option 1 **In person**

Option 2 **By live video on a computer, phone, or other device.** You can see and hear everyone, and they can see and hear you sign the form.

Option 3 **By audio only on a phone, tablet or computer** (witnesses only). You can hear everyone, and they can hear you, but you cannot see each other. **A notarial officer cannot do this option.**

When everyone is ready to witness you signing this form, write your name and write the date below.

- You can tell someone to sign for you if you cannot sign yourself.
- The person helping you sign the form cannot be a witness or notarial officer.
- You, your witnesses, and a notorial officer can also sign this form electronically.

sign your name _____ today's date _____

print your first name _____ print your last name _____ date of birth _____

address _____ city _____ state _____ zip code _____

If you do not have witnesses, a notary must sign on Page 15.

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Witnesses

By signing, we promise that _____ signed this form,
(the person named on Page 13)
they were thinking clearly, and were not forced to sign. We also **promise** that:

- We know this person, or they proved who they were
- We are 18 years of age or older
- We are not their health care representative
- We did not help them sign their name to this form
- At least one of us is not related to them by blood, marriage, or adoption

We also **promise** that they signed this form while we (mark only one):

- ◯ Met in person
- ◯ Saw and heard them sign on a live video call using a computer, phone, or other device. They could also see and hear us.
- ☐ Heard them sign while we listened on a phone, computer, or other device

  If we could hear but not see them, we also promise we followed Indiana law because we asked them questions to make sure it was really them. Here are the questions we asked and their answers:

  - What is your birthday? _____
  - What is your address? _____
  - Other question: _____
    Answer: _____

If we were not in person, we signed different copies of the form and will send our copies to them to put them together

Witness #1

sign your name _____ date _____

print your first name _____ print your last name _____

address _____ city _____ state _____ zip code _____

Witness #2

sign your name _____ date _____

print your first name _____ print your last name _____

address _____ city _____ state _____ zip code _____

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Notarial Officer

You can only use a notarial officer if they can see and hear you when you sign in person or on live video. You must also be able to:

- prove who you are with a photo ID (driver's license or passport)
- **or,** answer the notarial officer's questions to confirm who you are

State of Indiana

SS: _____

County of _____

Before me, a Notary Public, personally appeared _____ (name of signing Declarant), who acknowledged the execution of the foregoing Advance Directive as his or her voluntary act, and who, having been duly sworn, stated that any representations therein are true.

Witness my hand and Notarial Seal on this _____ day of _____, 20____.

_____
Signature of Notary Public

_____
Notary's Printed Name (if not on seal)

_____
Commission Number (if not on seal)

_____
Commission Expires (if not on seal)

_____
Notary's County of Residence

You are now done with this form.

Share this form with your family, friends, and medical providers. Talk with them about your medical wishes. To learn more go to www.prepareforyourcare.org.

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INDIANA ADVANCE CARE DIRECTIVE

INDIANA HEALTH CARE REPRESENTATIVE:
A Health Care Representative is a person chosen by you to make healthcare decisions, including end-of- life decisions, if you are unable to make your own. It is a good idea to talk with this person about your preferences ahead of time. A doctor will determine if you are unable to make your own decisions.

My name (also known as "Declarant"):

_____ _____
Full Legal Name Date of Birth (MM/DD/YYYY)

My Health Care Representative can make decisions for me if I cannot make and share my own health care decisions. My Health Care Representative must follow my wishes and values. My values include my ideas about dignity and quality of life. If my Health Care Representative does not know my wishes, my Health Care Representative must act in good faith and make decisions in my best interests. These decisions include but are not limited to:

- Agreeing to medical treatment
- Stopping medical treatment
- Refusing medical treatment
- Arranging comfort care

I want the following person to be my Health Care Representative (HCR):

_____ _____
HCR Name HCR Phone Number

If my primary HCR named above is not able or available to act for me, I want the following person to be my backup Health Care Representative:

_____ _____
Backup HCR Name Backup HCR Phone Number

OPTIONAL STATEMENT OF PREFERENCES:
I would like to provide some additional guidance for my Health Care Representative on my end-of-life preferences. (Please select only one option below).

☐ The ***quality of my life*** is more important than the length of my life. If I am unable to make my own decisions and my attending physician believes that I will not recover, I do not want treatments to prolong my life or delay my death. Instead, I would want treatment or care to make me comfortable and to relieve me of pain.

☐ ***Staying alive*** is more important to me, no matter how sick I am or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible, in accordance with reasonable medical standards.

☐ I choose to NOT complete this section at this time.

REQUIRED SIGNATURES:
By signing this form, I cancel and revoke every health care power of attorney I signed in the past.

_____ _____
Signature (Declarant) Date

_____
Printed Name (Declarant)

This form must be either signed by 2 adult witnesses (below left) or notarized (below right) to be legally valid.

SIGNATURE OF 2 ADULT WITNESSES

Each of the undersigned Witnesses confirms that he or she has received satisfactory proof of the identity of the Declarant and is satisfied that the Declarant is of sound mind and has the capacity to sign the above Advance Directive. **At least one of the undersigned Witnesses is not a spouse or other relative of the Declarant.**

_____
Signature of Adult Witness 1

_____
Printed Name of Adult Witness 1

_____
Date

_____
Signature of Adult Witness 2

_____
Printed Name of Adult Witness 2

_____
Date

_____ Initial here if the Witnesses participated by phone.

NOTARIZATION

STATE OF INDIANA)
) SS:
COUNTY OF _____)

Before me, a Notary Public, personally appeared _____ [*name of signing Declarant*], who acknowledged the execution of the foregoing Advance Directive as his or her voluntary act, and who, having been duly sworn, stated that any representations therein are true.

Witness my hand and Notarial Seal on this _____ day of _____, 20____.

_____
Signature of Notary Public

_____
Notary's Printed Name *(if not on seal)*

_____
Commission Number *(if not on seal)*

_____
Commission Expires *(if not on seal)*

_____
Notary's County of Residence

STATE OF INDIANA
OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION AND ORDER

State Form 49559 (R / 9-11)

This declaration and order is effective on the date of execution and remains in effect until the death of the declarant or revocation.

OUT OF HOSPITAL DO NOT RESUSCITATE DECLARATION

Declaration made this _____ day of _____, _____, being of sound mind and at least eighteen (18) years of age, willfully and voluntarily make known my desires that my dying shall not be artificially prolonged under the circumstances set forth below.

I declare:

My attending physician has certified that I am a qualified person, meaning that I have a terminal condition or a medical condition such that, if I suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period I would experience repeated cardiac or pulmonary failure resulting in death.

I direct that, if I experience cardiac or pulmonary failure in a location other than an acute care hospital, cardiopulmonary resuscitation procedures be withheld or withdrawn and that I be permitted to die naturally. My medical care may include any medical procedure necessary to provide me with comfort care or to alleviate pain.

I understand that I may revoke this Out of Hospital Do Not Resuscitate Declaration at any time by a signed and dated writing, by destroying or canceling this document, or by communicating to health care providers at the scene the desire to revoke this declaration.

I understand the full import of this declaration

Signature of declarant

Printed name of declarant

City and state of residence

The declarant is personally known to me, and I believe the declarant to be of sound mind. I did not sign the declarant's signature above, for, or at the direction of, the declarant. I am not a parent, spouse, or child of the declarant. I am not entitled to any part of the declarant's estate or directly financially responsible for the declarant's medical care. I am competent and at least eighteen (18) years of age.

Signature of witness	Printed name	Date *(month, day, year)*

Signature of witness	Printed name	Date *(month, day, year)*

OUT OF HOSPITAL DO NOT RESUSCITATE ORDER

I, _____, the attending physician of _____, have certified the declarant as a qualified person to make an Out Of Hospital Do Not Resuscitate Declaration, and I order health care providers having actual notice of this Out Of Hospital Do Not Resuscitate Declaration and Order not to initiate or continue cardiopulmonary resuscitation procedures on behalf of the declarant, unless the Out Of Hospital Do Not Resuscitate Declaration is revoked.

Signature of attending physician

Printed name of attending physician	Medical license number	Date *(month, day, year)*

INDIANA LIFE PROLONGING PROCEDURES DECLARATION

State Form 55315 (6-13)
Indiana State Department of Health – IC 16-36-4

This declaration is effective on the date of execution and remains in effect until revocation or the death of the declarant. This declaration should be provided to your physician.

LIFE PROLONGING PROCEDURES DECLARATION

Declaration made this _____ day of _____ *(month, year)*. I, _____ , being at least eighteen (18) years of age and of sound mind, willfully and voluntarily make known my desire that if at any time I have an incurable injury, disease, or illness determined to be a terminal condition I request the use of life prolonging procedures that would extend my life. This includes appropriate nutrition and hydration, the administration of medication, and the performance of all other medical procedures necessary to extend my life, to provide comfort care, or to alleviate pain.

In the absence of my ability to give directions regarding the use of life prolonging procedures, it is my intention that this declaration be honored by my family and physician as the final expression of my legal right to request medical or surgical treatment and accept the consequences of the request.

I understand the full import of this declaration.

Signed _____

_____
City, County, and State of Residence

WITNESSES

The declarant has been personally known to me and I believe (him/her) to be of sound mind. I am competent and at least eighteen (18) years of age.

Witness _____ Date *(month, day, year)* _____

Witness _____ Date *(month, day, year)* _____

INDIANA PHYSICIAN ORDERS FOR SCOPE OF TREATMENT (POST)

State Form 55317 (R3 / 5-18)
Indiana State Department of Health – IC 16-36-6

INSTRUCTIONS: This form is a physician's order for scope of treatment based on the patient's current medical condition and preferences. The POST should be reviewed whenever the patient's condition changes. A POST form is voluntary. A patient is not required to complete a POST form. A patient with capacity or their legal representative may void a POST form at any time by communicating that intent to the health care provider. Any section not completed does not invalidate the form and implies full treatment for that section. HIPAA permits disclosure to health care professionals as necessary for treatment. The original form is personal property of the patient. A facsimile, paper, or electronic copy of this form is a valid form.

Patient Last Name	Patient First Name	Middle Initial
Birth Date *(mm/dd/yyyy)*	Medical Record Number	Date Prepared *(mm/dd/yyyy)*

DESIGNATION OF PATIENT'S PREFERENCES: The following sections (A through D) are the patient's current preferences for scope of treatment.

A *Check One*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse AND is not breathing.

☐ Attempt Resuscitation / CPR ☐ Do Not Attempt Resuscitation / DNR

When not in cardiopulmonary arrest, follow orders in **B, C** and **D.**

B *Check One*

MEDICAL INTERVENTIONS: If patient has pulse AND is breathing OR has pulse and is NOT breathing.

☐ Comfort Measures (Allow Natural Death): Treatment Goal: Maximize comfort through symptom management. 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 to hospital only if comfort needs cannot be met in current location.

☐ Limited Additional Interventions: Treatment Goal: Stabilization of medical condition. In addition to care described in Comfort Measures above, use medical treatment for stabilization, IV fluids (hydration) and cardiac monitor as indicated to stabilize medical condition. May use basic airway management techniques and non-invasive positive-airway pressure. Do not intubate. Transfer to hospital if indicated to manage medical needs or comfort. Avoid intensive care if possible.

☐ Full Intervention: Treatment Goal: Full interventions including life support measures in the intensive care unit. In addition to care described in Comfort Measures and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. Transfer to hospital and/or intensive care unit if indicated to meet medical needs.

C *Check One*

ANTIBIOTICS:

☐ Use antibiotics for infection only if comfort cannot be achieved fully through other means.

☐ Use antibiotics consistent with treatment goals.

D *Check One*

ARTIFICIALLY ADMINISTERED NUTRITION: Always offer food and fluid by mouth if feasible.

☐ No artificial nutrition.

☐ Defined trial period of artificial nutrition by tube. (Length of trial: _____ Goal: _____)

☐ Long-term artificial nutrition.

OPTIONAL ADDITIONAL ORDERS:

SIGNATURE PAGE: This form consists of two (2) pages. Both pages must be present. The following page includes signatures required for the POST form to be effective.

Patient Name:_____ Date of Birth *(mm/dd/yyyy)*:_____

	SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE: In order for the POST form to be effective, the patient or legally appointed representative must sign and date the form below.
E	**SIGNATURE OF PATIENT OR LEGALLY APPOINTED REPRESENTATIVE** My signature below indicates that my physician or physician's designee discussed with me the above orders and the selected orders correctly represent my wishes.

Signature ***(required by statute)***	Print Name ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*

F	**CONTACT INFORMATION FOR LEGALLY APPOINTED REPRESENTATIVE IN SECTION E *(IF APPLICABLE)*:** If the signature above is other than patient's, add contact information for the representative.

Relationship of representative identified in Section E if patient does not have capacity ***(required by statute)***	Address *(number and street, city, state, and ZIP code)*	Telephone Number

PHYSICIAN ORDER:

A POST form may be executed only by an individual's treating physician, advanced practice registered nurse, or physician assistant, and only if:

(1) the treating physician, advanced practice registered nurse, or physician assistant has determined that:
- (A) the individual is a qualified person; and
- (B) the medical orders contained in the individual's POST form are reasonable and medically appropriate for the individual; and

(2) the qualified person or representative has signed and dated the POST form

A qualified person is an individual who has at least one (1) of the following:

(1) An advanced chronic progressive illness.
(2) An advanced chronic progressive frailty.
(3) A condition caused by injury, disease, or illness from which, to a reasonable degree of medical certainty:
- (A) there can be no recovery; and
- (B) death will occur from the condition within a short period without the provision of life prolonging procures.

(4) A medical condition that, if the person were to suffer cardiac or pulmonary failure, resuscitation would be unsuccessful or within a short period the person would experience repeated cardiac or pulmonary failure resulting in death.

G **DOCUMENTATION OF DISCUSSION: Orders discussed with *(check one)*:**

☐ Patient (patient has capacity) ☐ Health Care Representative ☐ Legal Guardian
☐ Parent of Minor ☐ Health Care Power of Attorney

H **SIGNATURE OF TREATING PHYSICIAN / ADVANCED PRACTICE REGISTERED NURSE / PHYSICIAN ASSISTANT**

My signature below indicates that I or my designee have discussed with the patient or patient's representative the patient's goals and treatment options available to the patient based on the patient's health. My signature below indicates to the best of my knowledge that these orders are consistent with the patient's current medical condition and preferences.

Signature of Treating Physician / APRN / PA ***(required by statute)***	Print Treating Physician / APRN / PA Name ***(required by statute)***	Date ***(required by statute)*** *(mm/dd/yyyy)*

Physician / APRN / PA office telephone number ***(required by statute)***	Physician / APRN / PA License Number ***(required by statute)***	Health Care Professional preparing form if other than the physician / APRN / PA

I **APPOINTMENT OF HEALTH CARE REPRESENTATIVE:** As patient you have the option to appoint an individual to serve as your health care representative pursuant to IC 16-36-1-7. You are not required to designate a health care representative for this POST form to be effective. You are encouraged to consult with your attorney or other qualified individual about advance directives that are available to you. Forms and additional information about advance directives may be found on the ISDH web site at http://www.in.gov/isdh/25880.htm.