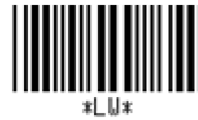
HSHS Sacred Heart St.Joseph's St.Vincent St.Mary's St.Nicholas St.Clare



LW

DAIM NTAWV TSO CAI RAWS KEV CAI LIJ CHOJ RAU KHO MOB

Thaum koj sau Daim Ntawv Tso Cai Raws Kev Cai Lij Choj rau Kho Mob, txhua cov lus teb nyob hauv tsab ntawv no yuav tsum sau ua ntawv Askiv

CEEB TOOM RAU TUS NEEG SAU DAIM NTAWV NO

KOJ MUAJ CAI LOS TXIAV TXIM SIAB TXOG KEV KHO KOJ TUS MOB. YUAV TSIS MUAJ KEV KHO MOB RAU KOJ DHAU NTAWM QHOV KOJ TXIAV TXIM, THIAB COV KEV KHO MOB UAS TSIM NYOG YUAV TSIS TSO TSEG LOSSIS NCUA TSEG YOG TIAS KOJ TXIAV TXIM LAWM

VIM TIAS KOJ COV KWS KHO MOB QEE ZAUS YUAV TSIS MUAJ LUB CAIJ NYOOG LOS TSIM KEV SIB CUAM TSHUAM SIJ HAWM NTEV NROG KOJ, FEEM NTAU LAWV YUAV TSIS SWM NROG KOJ COV KEV NTSEEG THIAB LUB MEEJ MOM THIAB COV NTAUB NTAWV TXOG KEV SIB TXHAWB HAUV KOJ TSEV NEEG. QHOV NO UA RAU MUAJ TEEBMEEM YOG TIAS KOJ DHAU UA IB TUS NEEG UAS LUB CEV LOSSIS LUB HLWB TSIS TUAJ YEEM TXIAV TXIM SIAB KOJ LI KEV KHO MOB TAU.

TXHAWM RAU ZAM TEJ TEEB MEEM ZOO LI NO, KOJ YUAV TAU KOS DAIM NTAWV NO QHIA TUS NEEG UAS MUAJ DAIM NTAWV TSO CAI RAWS KEV CAI LIJ CHOJ KEV KHO MOB RAU KOJ YOG KOJ TSIS TUAJ YEEM TXIAV TXIM SIAB TAU LOS NTAWM KOJ TUS KHEEJ. TUS NEEG NTAWV UAS HU TIAS KOJ LUB CHAW SAWV CEV KHO MOB. KOJ YUAV TAU SIV ME NTSIS SIJ HAWM THAM KOJ TXOJ KEV XAV THIAB KEV NTSEEG TXOG TEJ KEV SIV TSHUAJ NROG TUS NEEG NTAWV LOSSIS TUS NEEG UAS TEJ ZAUM KOJ XAV TIAS XAIV KOM UA TXOJ HAUM LWM NO. TEJ ZAUM KOJ KUJ TUAJ YEEM HAIS RAU HAUV TSAB NTAWV NO TXOG TXHUA HOM KEV KHO MOB UAS KOJ NYIAM LOSSIS TSIS NYIAM, THIAB KOJ KUJ YUAV TSO CAI KOM MUAJ CWJ CIAM RAU KOJ TUS NEEG SAWV CEV KHO MOB. YOG TIAS KOJ TUS NEEG SAWV CEV TSIS PAUB KOJ TXOJ KEV NTSHAW TXOG KEV TXIAV TXIM SIAB, NWS YUAV TAU SUAV XAM SEB YAM DAB TSI UAS YOG YAM KOJ XAV KOM UA TSHAJ PLAWS.

POWER OF ATTORNEY FOR HEALTH CARE DOCUMENT

As you complete this Power of Attorney for Health Care, all responses within this document must be in English.

NOTICE TO PERSON MAKING THIS DOCUMENT

YOU HAVE THE RIGHT TO MAKE DECISIONS ABOUT YOUR HEALTH CARE. NO HEALTH CARE MAY BE GIVEN TO YOU OVER YOUR OBJECTION, AND NECESSARY HEALTH CARE MAY NOT BE STOPPED OR WITHHELD IF YOU OBJECT.

BECAUSE YOUR HEALTH CARE PROVIDERS, IN SOME CASES, MAY NOT HAVE HAD THE OPPORTUNITY TO ESTABLISH A LONG-TERM RELATIONSHIP WITH YOU, THEY ARE OFTEN UNFAMILIAR WITH YOUR BELIEFS AND VALUES AND THE DETAILS OF YOUR FAMILY RELATIONSHIPS. THIS POSES A PROBLEM IF YOU BECOME PHYSICALLY OR MENTALLY UNABLE TO MAKE DECISIONS ABOUT YOUR HEALTH CARE.

IN ORDER TO AVOID THIS PROBLEM, YOU MAY SIGN THIS LEGAL DOCUMENT TO SPECIFY THE PERSON WHOM YOU WANT TO MAKE HEALTH CARE DECISIONS IF YOU ARE UNABLE TO MAKE THOSE DECISIONS PERSONALLY. THAT PERSON IS KNOWN AS YOUR HEALTH CARE AGENT. YOU SHOULD TAKE SOME TIME TO DISCUSS YOUR THOUGHTS AND BELIEFS ABOUT MEDICAL TREATMENT WITH THE PERSON OR PERSONS WHOM YOU HAVE SPECIFIED. YOU MAY STATE IN THIS DOCUMENT ANY TYPES OF HEALTH CARE THAT YOU DO OR DO NOT DESIRE, AND YOU MAY LIMIT THE AUTHORITY OF YOUR HEALTH CARE AGENT. IF YOUR HEALTH CARE AGENT IS UNAWARE OF YOUR DESIRES WITH RESPECT TO A PARTICULAR HEALTH CARE DECISION, HE OR SHE IS REQUIRED TO DETERMINE WHAT WOULD BE IN YOUR BEST INTERESTS IN MAKING THE DECISIONS.

NOV YOG IB TSAB NTAWV TSEEM CEEB HAUV KEV CAI LIJ CHOJ. NWS MUAB TXOJ CAI RAU KOJ TUS NEEG SAWV CEV KHO MOB TXIAV TXIM SIAB KHO MOB TAM KOJ. NWS TUAJ YEEJ THIM TXOJ CAI TUS SAWV CEV KHO MOB UAS KOJ MUAB RAU LAWV TAU TXHUA LUB SIJ HAWM. YOG KOJ XAV HLOOV TXOJ DAIM NTAWV TSO CAI RAWS KEV CAI LIJ CHOJ KEV KHO MOB, KOJ TUAJ YEEM THIM TSAB NTAWV NO TAU TXHUA LUB SIJ HAWM UAS YOG MUAB POV TSEG, UAS YOG KOM LWM TUS MUAB HLAWV LOSSIS POV TSEG RAU KOJ NTSIA NTSOOV, UAS YOG YUAV TAU KOS NPE TIAS QHOV KEV THIM NO MUAJ OB LEEG NYOB NTAWV UA POV THAWJ. YOG KOJ THIM, KOJ YUAV TAU QHIA KOJ TUS NEEG SAWV CEV, CHAW KHO MOB LOSSIS TXHUA QHOV UAS KOJ TAU LUAM IB DAIM XA MUS RAU LAWV. YOG TUS NEEG SAWV CEV KOJ YOG KOJ TUS TXIJ NKAWM LOSSIS COV TXHEEB ZE THIAB KOJ QHOV KEV SIB YUAV TAU THIM LOSSIS SIB NRAUJ LOSSIS KEV SIB TSO TAU TSHWM SIM TOM QAB KOS NPE RAU DAIM NTAWV NO, TSAB NTAWV XAM TIAS SIV TSIS TAU.

KOJ KUJ TSEEM LOSSISTUAJ YEEM SIV DAIM NTAWV NO LOS UA LOSSIS TSIS KAM LEES MUAB KOJ COV KHOOM HAUV NROG CEV PUB DAWB RAWS LI KOJ TXOJ KEV PLOJ TUAG. YOG KOJ SIV TAU TSAB NTAWV NO LOS UA LOSSIS TSIS KAM KEV PUB KHOOM NRUAB NROG CEV, TSAB NTAWV NO KUJ TSEEM THIM TAU TXHUA LUB SIJ HAWM YOG KOJ HLOOV SIAB. KOJ TUAJ YEEM YUAV HLOOV LOSSIS THIM KEV PUB KHOOM NRUAB NROG CEV TAU UAS YOG MUAB CWJ MEM LOS KOS TUA TAWM KAB NTAWV HAIS TXOG PUB KHOOM NRUAB NROG CEV NYOB RAU TSAB NTAWV NO.

TSIS TXHOB KOS NPE RAU TSAB NTAWV NO TSHWJ TSIS YOG TIAS KOJ NKAG SIAB ZOO.

QHOV ZOO TSHAJ KOJ YUAV TAU KHAWS DAIM NTAWV NO CIA ZOO NROG KOJ TUS KWS KHO MOB.

DAIM NTAWV TSO CAI RAWS KEV CAI LIJ CHOJ RAU KEV KHO MOB

Tsab ntawv tau tsim rau ___________ hnub ntawm ___________ (hli) ___________ (xyoo)

THIS IS AN IMPORTANT LEGAL DOCUMENT. IT GIVES YOUR AGENT BROAD POWERS TO MAKE HEALTH CARE DECISIONS FOR YOU. IT REVOKES ANY PRIOR POWER OF ATTORNEY FOR HEALTH CARE THAT YOU MAY HAVE MADE. IF YOU WISH TO CHANGE YOUR POWER OF ATTORNEY FOR HEALTH CARE, YOU MAY REVOKE THIS DOCUMENT AT ANY TIME BY DESTROYING IT, BY DIRECTING ANOTHER PERSON TO DESTROY IT IN YOUR PRESENCE, BY SIGNING A WRITTEN AND DATED STATEMENT OR BY STATING THAT IT IS REVOKED IN THE PRESENCE OF TWO WITNESSES. IF YOU REVOKE, YOU SHOULD NOTIFY YOUR AGENT, YOUR HEALTH CARE PROVIDERS AND ANY OTHER PERSON TO WHOM YOU HAVE GIVEN A COPY. IF YOUR AGENT IS YOUR SPOUSE OR DOMESTIC PARTNER AND YOUR MARRIAGE IS ANNULLED OR YOU ARE DIVORCED OR THE DOMESTIC PARTNERSHIP IS TERMINATED AFTER SIGNING THIS DOCUMENT, THE DOCUMENT IS INVALID.

YOU MAY ALSO USE THIS DOCUMENT TO MAKE OR REFUSE TO MAKE AN ANATOMICAL GIFT UPON YOUR DEATH. IF YOU USE THIS DOCUMENT TO MAKE, OR REFUSE TO MAKE, AN ANATOMICAL GIFT, THIS DOCUMENT REVOKES ANY PRIOR RECORD OF GIFT THAT YOU MAY HAVE MADE. YOU MAY REVOKE OR CHANGE ANY ANATOMICAL GIFT THAT YOU MAKE BY CROSSING OUT THE ANATOMICAL GIFTS PROVISION IN THIS DOCUMENT.

DO NOT SIGN THIS DOCUMENT UNLESS YOU CLEARLY UNDERSTAND IT.

IT IS SUGGESTED THAT YOU KEEP THE ORIGNAL OF THIS DOCUMENT ON FILE WITH YOUR PHYSICIAN.

POWER OF ATTORNEY FOR HEALTH CARE

Document made this ___________ day of ___________ (month) ___________ (year)

I. I. TSIM TUS DAIM NTAWV TSO CAI RAWS KEV CAI LIJ CHOJ RAU KEV KHO MOB

Kuv / I ______________________________________
(Ntaus lub npe, chaw nyob thiab hnub yug)

____

nco qab ntsoov tias, tsab ntawv no muaj lub hom phiaj tsim daim ntawv tso cai raws kev cai lij choj rau kev kho mob. Qhov kuv tau sau tsab ntawv tso cai raws kev cai lij choj rau kho mob no yog yeem ntawm tus kheej. Txawm tias kuv yuav sau tsab ntawv tso cai raws kev cai lij choj rau kho mob los xij, Kuv xav kom tau txais kev ceebtoom txhua yam txog thiab tso cai rau kuv koom nrog hauv txhua qhov kev txiav txim siab kho mob rau kuv, raws li thaum uas kuv tseem muaj peev xwm ua tau. Lub hom phiaj tsab ntawv no, "txiav txim siab kho mob" txhais tau tias yog lees kev txiav txim, kho, tsum, lossis txwv kev saib xyuas, kev kho mob, kev pab lossis kev phais mob, kev ntaus nqi lossis kho mob hlwb.
Ib qho ntxiv, tej zaum kuv, raws tsab ntawv no, qhia kuv qhov kev cia siab qhia txog kev paub khoom nruab nrog cev yog thaum kuv tag lub neej txoj sia.

II. KEV XAIV LUB CHAW SAWV CEV KHO MOB

Yog thaum kuv tsis tuaj yeem txiav txim siab kho kuv tus kheej lawm, vim kuv tus mob, kuv tau xaiv

____
(Ntaus lub npe, chaw nyob thiab naj npawb xov tooj)

____

los sawv cev kuv tus kheej rau lub hom phiaj kev txiav txim siab kho mob rau kuv. Yog tias nws tsis kam lossis tsis txaus siab ua raws li hais no, kuv thov xaiv

____
(Ntaus lub npe, chaw nyob thiab naj npawb xov tooj)

____

los sawv cev kuv tus kheej rau kev txiav txim siab kho mob rau kuv.

I. CREATION OF POWER OF ATTORNEY FOR HEALTH CARE

I ______________________________________
(print name, address and date of birth),

____

being of sound mind, intend by this document to create a power of attorney for health care. My executing this power of attorney for health care is voluntary. Despite the creation of this power of attorney for health care, I expect to be fully informed about and allowed to participate in any health care decisions for me, to the extent that I am able. For the purpose of this document, "health care decision" means an informed decision to accept, maintain, discontinue or refuse any care, treatment, service or procedure to maintain, diagnose or treat my physical or mental condition.

In addition, I may, by this document, specify my wishes with respect to making an anatomical gift upon my death.

II. DESIGNATION OF HEALTH CARE AGENT

If I am no longer able to make health care decisions for myself, due to my incapacity, I hereby designate

____
(print name, address and telephone number)

____

to be my health care agent for the purpose of making health care decisions on my behalf. If he or she is ever unable or unwilling to do so, I hereby designate

____
(print name, address and telephone number)

____

to be my alternate health care agent for the purpose of making health care decisions on my behalf.

Tsis hais ob tug uas kuv tau muab npe sawv cev ua tus sawv cev kho mob rau kuv yog kuv lub chaw kho mob, ib tus neeg ua hauj lwm hauv kuv qhov chaw kho mob, ib tus neeg ua hauj lwm hauv lub tsev kuv qhov chaw kho mob uas kuv yog tus neeg mob lossis kuv tus txij nkawm rau cov neeg hais los no, tshwj tsis yog nws yog kuv tus txheeb ze. Lub hom phiaj tsab ntawv no, "tsis muaj peev xwm" yuav tsum muaj 2 tug kws kho mob thiab ib tug kws paub txog kev puas hlwb tau los soj ntsuam kuv thiab kos npe hais tias kuv tsis tuaj yeem yuav nco meej kuv tsis tuaj yeem yuav muab tau txheej xwm meej tseeb lossis muab kev txiav txim siab thiab pom tias kuv tsis muaj peev xwm yuav txiav txim siab rau kev kho kuv tus kheej lawm. Yuav tau luam ib daim khaws cia nrog tsab ntawv no.

III. COV NTSIAB LUS TSO CAI DAIM NTAWV TSO CAI RAWS KEV CAI LIJ CHOJ UA TSWV

Tshwj tsis yog tias kuv tau hais lwm yam rau hauv tsab ntawv no, yog kuv tau hais rau kuv qhov chaw kho mob kom lawv txiav txim kev kho mob sawv cev rau kuv, yog tias kuv xav tau kev kho mob, rau txhua yam ntawm kuv li kev noj qab haus huv thiab kev kho mob. Kuv tau tham yam uas kuv nyiam rau kuv tus sawv cev kho mob thiab ntseeg tias nws nkag siab kuv lub siab txog kev txiav txim siab uas kuv xav tau yog tias kuv tsis taus lawm. Kuv nyiam kom kuv txoj kev cia siab yog tau ua raws li qhov kev tso cai uas tau muab rau tus sawv cev kho mob nyob hauv tsab ntawv no.

Yog tas kuv tsis taus lawm, vim kuv mob nyhav, kev txiav txim siab kho mob, kuv qhov chaw kho mob yog tus los txiav txim siab kho mob rau kuv, tiam sis kuv qhov chaw kho mob yuav tsum tham nrog kuv yog tias kuv tseem tham lus tautham lus, nrog rau kev npog qhov muag. Yog tias tsis tuaj yeem tham lus tau lawm, kuv tus sawv cev kho mob yuav tsum txiav txim siab raws li qhov nws xaiv uas kuv tau hais rau nws raws lub sij hawm uas yuav tau txiav txim siab. Yog tias kuv tsis tau hais ib qho kev xaiv twg txog kev kho kuv tus mob txog tej lus nug thiab tsis tuaj yeem txuas lus tau lawm, kuv tus sawv cev kho mob yuav tsum txiav txim siab raws li qhov nws xaiv lossis qhov nws ntseeg tias yog qhov kuv nyiam.

Neither my health care agent nor my alternate health care agent whom I have designated is my health care provider, an employee of my health care provider, an employee of a health care facility in which I am a patient or a spouse of any of those persons, unless he or she is also my relative. For purposes of this document, "incapacity" exists if 2 physicians or a physician and a psychologist who have personally examined me sign a statement that specifically expresses their opinion that I have a condition that means that I am unable to receive and evaluate information effectively or to communicate decisions to such an extent that I lack the capacity to manage my health care decisions. A copy of that statement must be attached to this document.

III. GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care agent, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care agent and believe that he or she understands my philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care agent under this document.

If I am unable, due to my incapacity, to make a health care decision, my health care agent is instructed to make the health care decision for me, but my health care agent should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care agent shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care agent shall base his or her health care decision on what he or she believes to be in my best interest.

IV. CWJ CIAM RAU KEV KHO TUS MOB VWM

Kuv tus sawv cev kho mob yuav tsis sau npe lossis cog lus rau kuv thaum mus pw tsev kho mob uas yog kho mob hlwb, ib lub chaw saib xyuas hom nrab yuav muaj rau tus neeg uas puas hlwb, tsev kho mob hauv xeev lossis tsev kho mob. Kuv tus sawv cev kho mob tej zaum yuav tsis tso cai ua kev sim kho mob hlwb ua kev tshawb fawb lossis kev kho sab kev ntseeg, kev kho uas siv electroconvulsive lossis cov tsheej txheem kho cov mob vwm rau kuv.

V. SAU NPE THOV IB TUS KWS TU NEEG MOB HAUV TSEV LOSSIS HAUV ZEJ ZOG RAWS LI QHOV CHAW NYOB HAUV LUB TSEV KHO MOB

Kuv tus sawv cev kho mob kuj yuav sau npe kuv rau ib kws tu neeg mob tu hauv tsev lossis ib qhov chaw kho mob nyob hauv zej zog tuaj saib ib ntus lossis so tos me ntsis.

Yog tias kuv tau kos rau "Yog" rau cov hauv qab no, kuv tus sawv cev kho mob tej zaum kuj yuav sau npe kuv rau tshaj qhov uas nyob ib ntus lossis nyob tos, yog tias ho kos rau "Tsis yog" rau qhov hauv qab no, kuv tus sawv cev kho mob tej zaum yuav tsis sau kuv npe rau:

1. Ib kws tu neeg mob tu tom tsev ☐ Yog ☐ Tsis yog
2. Ib qhov chaw kho mob nyob hauv zej zog
   ☐ Yog ☐ Tsis yog

Yog tias kuv tsis kos rau qhov "Yog" lossis "Tsis yog" rau qhov sab sauv tam siv kuv tus sawv cev kho mob kuj yuav sau npe rau kuv tsuas yog ib ntus xwb lossis ncua kev kho mob me ntsis.

VI. COV NTSIAB LUS NTSIG TXOG KEV NOJ UAS SIV LUB RAJ HLIV LAWM XWB

Yog tias kuv kos rau qhov "Yog" rau hauv qab no, kuv tus sawv cev kho mob yuav tsum lossis thim qhov siv lub raj pub khoom noj rau kuv, tshwj tsis yog tias kuv tus kws kho mob kom ua, raws li nws qhov kev txiav txim siab, qhov no yuav ua rau mob lossis nws yuav nyob nyuaj dua. Yog tias kuv kos rau qhov "Tsis yog" rau hauv qab no, kuv tus sawv cev kho mob yuav tsis tsum lossis thim qhov siv lub raj pub khoom noj rau kuv.

IV. LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care agent may not admit or commit me on an inpatient basis to an institution for mental diseases, an intermediate care facility for persons with an intellectual disability, a state treatment facility or a treatment facility. My health care agent may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment or drastic mental health treatment procedures for me.

V. ADMISSION TO NURSING HOMES OR COMMUNITY-BASED RESIDENTAIL FACILITIES

My health care agent may admit me to a nursing home or community-based residential facility for short-term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care agent may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care agent may not so admit me:

1. A nursing home ☐ Yes ☐ No
2. A community-based residential facility
   ☐ Yes ☐ No

If I have not checked either "Yes" or "No" immediately above, my health care agent may admit me only for short-term stays for recuperative care or respite care.

VI. PROVISION OF A FEEDING TUBE

If I have checked "Yes" to the following, my health care agent may have a feeding tube withheld or withdrawn from me, unless my physician has advised that, in his or her professional judgment, this will cause me pain or will reduce my comfort. If I have checked "No" to the following, my health care agent may not have a feeding tube withheld or withdrawn from me.

Kuv tus sawv cev kho mob yuav tsis tso tseg kev noj lossis kev haus pub rau kuv tshwj tsis yog tias muaj kev qhia txog tias kev kho mob yuav tau caiv txhob noj.

Tsum lossis thim kev pub mov uas siv lub raj ☐ Tis ☐ Tis Yog

Yog tias kuv tsis kos rau qhov "Yog" lossis "Tsis yog" rau qhov sab sauv kuv tus sawv cev kho mob tej zaum kuj yuav tsis thim kev pub khoom noj uas yog siv lub raj pub ntawm kuv mus.

VII. KEV TXIAV TXIM SIAB KHO MOB RAU COV POJ NIAM CEV XEEB TUB

Yog tias kuv tau kos rau "Yog" rau hauv qab no, kuv tus sawv cev kho mob tej zaum yuav txiav txim siab rau kuv tsis hais kuv lub cev xeeb tub los xij. Yog tias kuv tau kos rau "Tsis yog" rau hauv qab no, kuv tus sawv cev kho mob tej zaum yuav tsis txiav txim siab rau kuv tsis hais kuv lub cev xeeb tub lawm.

Kev txiav txim siab kho mob yog kuv lub cev xeeb tub lawm
☐ Tis ☐ Tis Yog

Yog tias kuv tsis tau rau qhov "Yog" lossis "Tsis yog" rau sab sauv tam siv, kuv tus sawv cev kho mob tej zaum yuav tsis txiav txim siab rau kuv tsis hais kuv lub cev xeeb tub lawm.

VIII. NTSIAB LUS QHIA TXOG QHOV UAS NYIAM, QHOV TSHWJ XEEB LOSSIS COV KEV TXWV

Raws qhov kev tso cai nyob tsab ntawv no kuv tus neeg sawv cev kho mob yuav tsum ua raws kuv txoj kev ntshaw, yog muaj dab tsi, thiab hais txog tej yam tshwj xeeb lossis cov kev txwv uas kuv tau hais tseg. Hauv qab no yog kuv txoj kev ntshaw, cov los qhia lossis cwj ciam uas kuv xav hais (ntxiv ntau kab rau yog tseem muaj ntau):

____

____

____

____

My health care agent may not have orally ingested nutrition or hydration withheld or withdrawn from me unless provision of the nutrition or hydration is medically contraindicated.

Withhold or withdraw a feeding tube ☐ Yes ☐ No

If I have not checked either "Yes" or "No" immediately above, my health care agent may not have a feeding tube withdrawn from me.

VII. HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my health care agent may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

Health care decisions if I am pregnant
☐ Yes ☐ No

If I have not checked either "Yes" or "No" immediately above, my health care agent may not make health care decisions for me if my health care agent knows I am pregnant.

VIII. STATEMENT OF DESIRES, SPECIAL PROVISIONS OR LIMITATIONS

In exercising authority under this document, my health care agent shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are specific desires, provisions or limitations that I wish to state (add more items if needed):

____

____

____

____

IX. QHOV KOJ NYIAM KHO KOM TXOJ SIA NYOB NTEV LI QHOV UA TAU (KEV XAIV)

(kos lub lub voj voos yog siv tau.)

Kuv tau ua tib zoo xav thiab qhov kev ntoog mob uas kho ua ntu zus tab txawm yuav mob txom nyem ntev, kev mob txom nyem, kev mob uas tsis pab ntaus nqi, lossis tab txawm tias nws muaj qhov tias kuv zoo tsis tau rov qab:

- ☐ Kuv tseem xav tau txhua yam kev kho uas tsim nyog los ntawm kuv tus kws kho mob thiab tus sawv cev txog thaum kuv tus kws kho mob thiab tus sawv cev pom tias qhov kev kho mob ntawv yuav puas tsuaj lossis tsis muaj txiaj ntsim dab tsi ntxiv lawm.

lossis

- ☐ Kuv xav thim tag nrho cov kev kho uas ua rau kuv nyob tau ntev mus ntxiv xwb tab sis zoo tsis taus. Qhov no suav nrog tab sis tsis tas rau, lub tshuab pab kom los siav/pab ua pa (tshuab pab ua pa), cov ntshaiv txhaj hauv lub cev thiab cov tshuaj tiv thaiv, tshuaj kho mob thiab cov kev kho mob uas kuv tau txais thaum kho tus mob loj tsis zoo tu qab lossis lwm yam tshuaj kho mob tshwj tsis yog tau ncua lossis thim cov kev kho mob no yuav ua rau kuv mob lossis tsis xis nyob.

Qhov kev xaiv, kuv nkag siab tias kuv yuav tau txais thuaj kom txhob mob thiab nyob taus, nrog rau khoom noj thiaj dej haus los ntawm qhov ncauj yog tias kuv tseem nqos taus tsis muaj kev phom sij.

X. KEV NIAS HAUV SIAB PAB TXOJ SIA (CPR) (Kev xaiv)

CPR yog ib txoj kev pab thaum lub plawv nres lawm kom nws rov ntoj thiab ua taus pa. Nws yuav muaj kev nias hauv siab (siv zog nias ntawm lub hauv siab kom lub plawv rov txau tau ntshav), tshuaj, hluav taws xob hlawv thiab lub raj pab ua pa. Kuv nkag siab tias PCR tej thaum kuj yuav pab tau kuv txoj sia. Kuv kuj nkag siab zoo lawm tias tej thaum kuj pab tsis tau cov neeg uas mob ntev los lawm thiab/lossis muaj tus mob loj. Kuv nkag siab tias yog kuv tsis kom ua CPR thiab kuv nyiam kom cia tag lub neej txoj sia li nws txoj hmoo, kuv tus kws kho mob yuav tsum paub txog qhov no. Yog li ntawv:

(kos rau lub voj yog tias siv tau.)

IX. PREFERENCES REGARDING ATTEMPTS AT LIFE PROLONGING TREATMENTS (OPTIONAL)

(check the box if it applies.)

I have considered the benefits and burdens of continued treatment in the event of prolonged suffering, terminal illness or irreversible diagnoses, or in the event that it is reasonably certain that I will not recover from my condition:

- ☐ I do want all appropriate treatments recommended by my doctor until my doctor and agent agree that such treatments are harmful or no longer beneficial.

or

- ☐ I want to stop or withhold all treatments that might be used to prolong my dying. This includes, but is not limited to, respirator/ventilator (breathing machine), administration of blood products and antibiotics, medications and interventions that I have received for chronic medical conditions or other medications unless the withholding or withdrawal of these treatments would cause me pain or discomfort.

With either choice, I understand I will continue to receive pain and comfort medicines, as well as food and fluids by mouth if I am able to swallow safely.

X. CARDIOPULMONARY RESUSCITATION (CPR) (OPTIONAL)

CPR is a treatment used to attempt to restore heart rhythm and breathing when they have stopped. It may include chest compressions (forceful pushing on the chest to make the heart contract), medicines, electrical shocks and a breathing tube. I understand that CPR may save my life. I also understand that it does not work as well for people who have chronic (long-term) diseases and/or impaired functioning. I understand that if I do not want CPR attempted and prefer to allow a natural death, my physician should be made aware of this choice. Therefore:

(check the box if it applies.)

☐ Kuv xav tau kev nias hauv siab pab txoj sia (CPR) tshwj tsis yog tias kuv tus kws kho mob pom ib qho hauv qab no:

- Kuv tus mob kho tsis tau zoo lawm lossis raug mob thiab li cas los yeej yuav tuag xwb; lossis,
- Kuv yuav ua tsis tau neeg nyob mus ntxiv lawm yog thaum kuv lub plawv nres lawm; lossis,
- Kuv yuav ua tsis tau neeg nyob mus ntxiv lawm yog thaum kuv lub plawv nres lawm thiab yog ua rau rov ciaj los yuav txom nyem heev.

lossis

☐ Kuv tsis xav kom ua CPR yog kuv plawv nres lawm, tiam sis xav cia txoj sia tu raws li txoj hmoo.

Xaim lwm yam, kuv xav kom ua DNR txoj hlua caj dab los ntawm kuv tus kws kho mob yog kuv muaj cai txais tshuaj thiab tsis xav tau cov neeg ua hauj lwm los ua CPR rau kuv.

XI. LWM YAM KEV KHO TSEEM CEEB RAU KUV (KEV XAIV)

Txheej xwm txog kev cai dab qhuas/neeb yaig/kev coj noj coj ua uas koj xav kom koj tus neeg sawv cev tiab tsev neeg/phooj ywg paub:

____

____

____

____

☐ Kuv xav tau kuv tus neeg coj dab qhuas/txiv neeb (qhia seb thaum twg)

____

____

____

____

____

☐ I want Cardiopulmonary Resuscitation (CPR) attempted unless my physician determines one of the following:

- I have an incurable illness or injury and am dying; or,
- I have no reasonable chance of survival if my heart stops; or,
- I have little chance of long-term survival if my heart stops and the process of resuscitation would cause significant suffering.

or

☐ I do not want CPR attempted if my heart stops, but rather want to allow a natural death to occur.

With either choice, I will need to obtain a DNR bracelet from my physician if I have a qualified medical condition and do not want emergency personnel to perform CPR.

XI. OTHER IMPORTANT ASPECTS OF MY CARE (OPTIONAL)

Religious/Spiritual/Cultural information you would like your health care team and family/friends to know:

____

____

____

____

☐ I want my spiritual leader/clergy be contacted (specify when)

____

____

____

____

____

☐ Kuv yuav uas twb zoo ua kom tau txais Yam Nco Tseg Zoo
Yog tias ze qhov kuv yuav tag lub neej txoj sia thiab hais tsis taus lawm, kuv xav kom kuv tsev neeg/phooj ywg paub: ______________________________

____

____

____

____

☐ I desire efforts be made so I can receive the Sacraments

If I am nearing my death and cannot speak, I want my family/friends to know: ______________________________

____

____

____

____

XII. KHOOM PLIG KHOOM NRUAB NROG CEV (KEV XAIV)

Yog thaum kuv tag lub neej txoj sia:

☐ Kuv xav muab kuv qhov khoom nruab nrog cev lossis feem hauv qab no pub dawb
(qhia yam khoom nruab nrog cev lossis yam khoom yuav muab pub)

☐ Kuv xav muab kuv qhov khoom nruab nrog cev lossis ib feem pub dawb. *(https://health.wisconsin.gov/donorRegistry/public/donate.html)*

☐ Kuv xav muab kuv lub cev pub rau cov xav coj mus ua kev kawm yog xa tau. Yog xav paub ntau yam ntxiv thov tiv tauj rau Tsev Kawm Medical College of Wisconsin ntawm or the University of Wisconsin-Madison.

☐ Kuv tsis kam muab kuv lub cev pub coj mus ua kev kawm. (Yog tias kuv thim qhov kev cog lus yuav muab khoom nruab nrog cev pub rau ib tug neeg, kuv yuav qhia rau tus neeg ntawv lossis qhia tus neeg uas kuv tau pom zoo yuav muab khoom nruab nrog cev pub).

Yog tias kuv tsis kos ib kab twg sab sauv li ces tsis txhais tau tias kuv nyiam tlossis tsis kam muab kuv tej khoom nruab nrog cev pub rau lwm tus.

Kos npe: ______________________________

Hnub tim: ______________________________

XII. ANATOMICAL GIFTS (OPTIONAL)

Upon my death:

☐ I wish to donate only the following organs or parts *(specify the organs or parts)*.

☐ I wish to donate any needed organ or part. *(https://health.wisconsin.gov/donorRegistry/public/donate.html)*

☐ I wish to donate my body for anatomical study if needed. More information can be found by contacting Medical College of Wisconsin or the University of Wisconsin-Madison.

☐ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate).

Failing to check any of the lines immediately above creates no presumption about my desire to make or refuse to make an anatomical gift.

Signature: ______________________________

Date: ______________________________

XIII. KUAJ THIAB NTHUAV TAWM COV TXHEEJ XWM NTSIG TXOG KUV LI KEV KHO MOB LOSSIS MOB VWM

Hais txog tus cwj ciam hais nyob rau tsab ntawv no, kuv tus neeg sawv cev muaj cai ua cov hais hauv qab no:

(a) Thov, soj ntsuam thiab txais txhua cov txheej xwm, hais ntawm qhov ncauj lossis sau ua ntaub ntawv zias, txog kuv tus mob thiab mob vwm, nrog rau tej ntaub ntawv tshuaj thiab cov ntawv kho mob hauv tsev kho mob.

(b) Sawv cev kuv tus kheej txhua cov ntaub ntawv uas yuav tau siv txhawm rau tau cov xwm txheej uas hais los no.

(c) Tso cai rau nthuav tawm cov txheej xwm no.

(Tus mob thiab cov pov thawj yuav tsum kos npe rau daim ntawv thooj txhij.)

XIV. KOS NPE TUS NEEG MOB

(tus uas ua daim ntawv tso cai raws kev cai lij choj rau kho mob)

Kos npe: ______________________________

Hnub tim: ______________________________

(Kev kos npe rau ntawm daim ntawv no los ntawm tus thawj tswj hwm yog thim txhua cov ntaub ntawv tso cai raws kev cai lij choj rau kho mob yav dhau los)

XV. COV NTSIAB LUS NTAWM TUS POV THAWJ

Kuv paub tus neeg mob zoo thiab kuv ntseeg yam nws hais yuav muaj tseeb thiab nws muaj hnub nyoog tsawg kawg 18 xyoo. Kuv ntseeg tias qhov uas nws sau daim ntawv tso cai raws kev cai lij choj rau kho mob yog kev yeem ntawm tus kheej. Kuv muaj hnub nyoog yam tsawg 18 xyoo, kuv tsis txheeb ze tus mob uas yog koom roj koom ntshav, sib yuav, lossis niam qhuav txiv qhuav, kuv tsis yog txheeb ze raws txoj cai ch.770 ntawm txoj cai, thiab kuv tsis muaj feem lav them nyiaj txiag rau tus mob qhov kev kho mob.

XIII. INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care agent has the authority to do all of the following:

(a) Request, review and receive any information, oral or written, regarding my physical or mental health, including medical and hospital records.

(b) Execute on my behalf any documents that may be required in order to obtain this information.

(c) Consent to the disclosure of this information.

(The principal and the witnesses all must sign the document at the same time.)

XIV. SIGNATURE OF PRINCIPAL

(person creating the power of attorney for health care)

Signature: ______________________________

Date: ______________________________

(The signing of this document by the principal revokes all previous powers of attorney for health care documents)

XV. STATEMENT OF WITNESSES

I know the principal personally and I believe him or her to be of sound mind and at least 18 years of age. I believe that his or her execution of this power of attorney for health care is voluntary. I am at least 18 years of age, am not related to the principal by blood, marriage, or adoption, am not the domestic partner under ch.770 of the principal, and am not directly financially responsible for the principal's health care.

Kuv tsis yog ib qho chaw kho mob uas kho tus neeg mob rau lub sij hawm no, tsis yog neeg ua hauj lwm rau hauv chaw kho mob, tsis yog xib fwb lossis neeg ua hauj lwm pab tib neeg, ntawm tus neeg mob uas nyob rau lub chaw kho mob uas tus neeg mob. Kuv tsis yog tus sawv cev rau tus neeg mob. Raws li qhov kuv paub, kuv tsis muaj cai thiab tsis muaj peev xwm yuav los ua tswv ntawm tus mob tej cuab yeej ntawm lub neej.

Tus pov thawj 1:

(ntaus) Lub Npe: ______________________

Hnub tim:______________________

Hnub tim:______________________

____

Kos npe: ______________________

Tus pov thawj 2:

(ntaus) Lub Npe: ______________________

Hnub tim:______________________

Hnub tim:______________________

____

Kos npe: ______________________

I am not a health care provider who is serving the principal at this time, an employee of the health care provider, other than a chaplain or a social worker, or an employee, other than a chaplain or a social worker, of an inpatient health care facility in which the declarant is a patient. I am not the principal's health care agent. To the best of my knowledge, I am not entitled to and do not have a claim on the principal's estate.

Witness No.1:

(print) Name: ______________________

Date: ______________________

Address: ______________________

____

Signature: ______________________

Witness No.2:

(print) Name: ______________________

Date: ______________________

Address: ______________________

____

Signature: ______________________

XVI. COV NTSIAB LUS TUS SAWV CEV KHO MOB THIAB SAWV CEV KHO MOB THIB OB

Kuv nkag siab tias ______________________________(npe tus neeg mob) tau xaiv kuv los ua nws tus sawv cev kho mob lossis tus sawv cev kho mob thib ob los pab nws txiav txim siab kev kho mob thaum nws mob nyhav lossis thaum nws tsis tuaj yeem txiav txim siab tau lawm. ________________________ (npe tus neeg mob) tau tham txog nws txoj kev kho mob uas nws nyiam rau kuv lawm.

Tus sawv cev Kos npe: ________________________________

Hnub tim:____

Tus sawv cev thib ob Kos npe: __________________________

Hnub tim:____

XVI. STATEMENT OF HEALTH CARE AGENT AND ALTERNATE HEALTH CARE AGENT

I understand that ____________________________________ (name of principal) has designated me to be his or her health care agent or alternate health care agent if he or she is ever found to have incapacity and unable to make health care decisions himself or herself. ___________________________ (name of principal) has discussed his or her desires regarding health care decisions with me.

Agent's signature: ____________________________________

Address: ____

Alternate's signature:__________________________________

Address: ____