What A Living Will Is

A Living Will is a document in which you tell others of your wishes to be allowed to die a natural death – if you should become unable to express your wishes in the future. The Living Will tells medical professionals and members of your family to what extent special means should or should not be used to keep your body alive if you are incurably ill. The Living Will allows you to refuse certain medical procedures that may only prolong dying, or maintain the body in an unconscious state. The Living Will is to be used only if you become terminally ill or permanently unconscious.

Should I Have A Living Will?

It is not necessary that you be seriously ill or anticipating illness in order to benefit from a Living Will. In fact, a Living Will can help protect your family members from unnecessary emotional stress resulting from having to make important decisions in an unexpected crisis. A Living Will enables you to control the extent to which extraordinary measures will be used to prolong your life, and it relieves others from the responsibility of having to make such decisions.

What Types Of Treatment Are Affected?

Your Living Will affects only those types of treatments which, in the opinion of your doctor, would only serve to postpone the moment of death by artificially altering your body's vital functions. Some examples include:

- **Artificial Feeding:** If a patient is no longer able to swallow food, nourishment may be supplied through tubes inserted in the nose or incision in the abdomen.
- **Artificial Ventilation:** Machines which assist or control your breathing are called ventilators. Some patients are totally dependent on ventilators and would die without their support. A Living Will can address the question of continuing such support when there is no prospect of improvement
- **Cardiopulmonary Resuscitation** (CPR): When the heart stops (cardiac arrest), a special measure called cardiac resuscitation may be used to try to restart the heart. CPR includes the use of heart massage, intravenous medicines and electrical shock. Your Living Will may direct that any or all of these not be used.

Does This Mean Giving Up Or Stopping Care?

A Living Will affects only measures which are deemed to be useless. Making a Living Will does not mean that you will be abandoned. Doctors and nurses will continue attending to your needs, and every effort will be made to keep you comfortable. Humane treatment will continue.

What Is Healthcare Proxy?

You can choose to have another person make your healthcare decisions for you, if you should become unable to make decisions. The person you choose is called your "health care proxy". A proxy can be helpful if circumstances arise that are not covered in your Living Will. A proxy can be named on the attached form.

How To Make A Living Will Or Healthcare Proxy

To make a Living Will, you may fill out the form included on the back of this pamphlet. Have two other adults witness your signature. If you have decided to name a healthcare proxy, fill out the optional Healthcare Proxy. (If you wish to donate any organs, fill out the organ donation form, also included on this pamphlet)

What To Do With Your Living Will

It is important that your doctor and family members know about your Living Will and have a copy of it. Take a copy with you to the hospital. It is important that your doctor and family members know in advanced about your Living Will or Healthcare Proxy. Keep your original.

And If You Change Your Mind

Your Living Will or Healthcare Proxy can be revoked at any time by telling your doctor or family members that your wishes have changed. All copies of a Living Will or Healthcare Proxy to be revoked also should be destroyed.

Can One person Make A Living Will For Another?

If the patient is a child or an adult who can no longer make medical decisions a close family members or guardian can make a Living Will for the patient.

Help Is Available

Your Living Will involves some of life's most important choices and ethical considerations. Such choices are not always easy, but help is available. You may wish to ask your doctor to discuss these questions with you, or refer you to others who are qualified to help. Discussing these considerations with family members may serve to clarify questions you may have.

YOUR LIVING WILL

It is the Policy of Unity Health to respect patients' rights to refuse unwanted treatment and comply with any Living Will.

Adult patients of sound mind have a right to accept or refuse any medical or surgical treatment. This includes the right to accept or refuse treatment through a Living Will.

Additional copies of this brochure are available from:

Unity HEALTH

3214 E. Race Ave.
Searcy, AR 72143
(501) 268-6121

1205 McLain St.
Newport, AR 72112
(870) 523-8911

Unity-Health.org

Instructions for using this document: This document includes a Living Will and a Healthcare Proxy form. You may fill out one or both of the forms. Make any changes you want. Then sign in front of two witnesses. If you want both the Living Will and the Healthcare Proxy, you must sign and date this document in two places. The document does not have to be notarized.

Declaration

of_____

NAME OF DECLARANT

If I should have an incurable or irreversible condition that will cause my death within a relatively short time, or if I should become permanently unconscious, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain.

☐ Yes ☐ No **CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.

☐ Yes ☐ No **Life Support / Other Artificial Support:** Continuous use of breathing machine. IV fluids, medications, and other equipment that helps the lungs, heart, kidneys and other organs to continue to work.

☐ Yes ☐ No **Treatment of New Conditions:** Use of surgery blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.

☐ Yes ☐ No **Tube feeding/IV fluids:** Use of tubes to deliver food and water to patient's stomach or use of IV fluids into a vein which would include artificially delivered nutrition and hydration.

Signed this _____ day of _____, 20 _____.

_____ _____

Signature Address/City/State/Zip

The declarant voluntarily signed this writing in my presence.

_____ _____

Witness Address/City/State/Zip

_____ _____

Witness Address/City/State/Zip

Durable Power of Attorney for Healthcare

of_____

NAME OF DECLARANT

Pursuant to the Arkansas Durable Power of Attorney for Health Care Act (Ark. Code Ann. § 20-13-104) (the "Act"), I hereby designate and appoint _____ as my agent, or attorney in fact, to make decisions regarding my health care during periods when my health care provider has determined that I lack capacity to decide for myself. Specifically, and not to limit any other rights prescribed under the Act, my attorney-in-fact shall have the power to have access to my medical records for treatment or payment decisions; to disclose medical records to others for purposes of treatment, payment, or health care operations; to employ and discharge physicians; to consent to or refuse to consent to medical procedures, including the withholding or withdrawal of life-sustaining treatment, and nutrition and hydration, according to my wishes expressed in my Living Will, or, if my wishes are unclear under the then existing circumstances of my medical condition, then upon consideration of my best interests as determined by my physician in consultation with my agent; to admit me to hospitals, including psychiatric hospitals, nursing homes, or hospice care; and to sign all appropriate forms, consents and releases in connection with any of said matters.

If _____ resigns, or is not able or available to make health care decisions for me, or if an agent named by me is divorced from me or is my spouse and legally separated from me, I appoint _____ as successor, with all of the rights and powers and authority herein stated. The term "health care" shall have the meaning set forth in Ark. Code Ann. § 20-13-104(c). This Durable Power of Attorney for Health Care shall not be affected by my subsequent disability or incapacity.

Signed this _____ day of _____, 20 _____.

_____

Signature

We, the undersigned, do hereby certify that the Declarant, _____ subscribed this Durable Power of Attorney for Health Care in our presence, and we, at his or her request, in his or her presence, and in the presence of each other, signed as attesting witnesses, and we do further certify that the Declarant appeared to be eighteen years of age or older, of sound mind, and acting without undue influence, fraud or restraint and that his or her signature was voluntary.

_____ _____

Witness Address/City/State/Zip

_____ _____

Witness Address/City/State/Zip