

Honoring Choices Massachusetts and Rhode Island Partners

Rhode Island Care Planning Tool Kit

Start to make your own personal health care plan!



Starting at 18 years old, adults can make their own health care decisions and write down their decisions in a health care plan. This tool kit includes Rhode Island care planning information, documents, and resources to help you started to make a plan and connect to care.



Thanks to Rhode Island Partners who provided guidance for the tool kit.

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Rhode Island Care Planning Tool Kit

Adults can start to make a personal care plan by completing a Durable Power of Attorney for Health Care, and adding documents as their health needs change over time. With guidance from our Rhode Island (RI) Partners, we've assembled a simple care planning tool kit that includes RI planning information and documents, and links to handy resources.

RI Care Planning Documents

Here are the three documents you can use over your lifetime to make your personal plan.

1. RI Durable Power of Attorney for Health Care.

Adults have the fundamental right to control their medical care decisions and to make a written durable power of attorney. A Durable Power of Attorney for Health Care is a document that gives the person you designate as your agent the power to make health care decisions for you, if you are unable to make medical decisions for yourself. Under [Rhode Island law](#), all Durable Powers of Attorney for Health Care forms that conform with the RI legal requirements can be used to establish a valid document. Consumers can choose the document they'd like to use. Below are two documents you can choose from; we do not recommend or endorse any one form. The paper forms are attached; the links below offer fillable documents.

- RI Durable Power of Attorney for Healthcare Statutory Form
 - [English](#)
- RI Durable Power of Attorney for Health Care, "A GIFT OF PREPAREDNESS"
 - [English](#)
 - [Spanish](#)

2. RI Living Will

Adults can instruct their physicians to withhold or withdraw life-sustaining procedures in the event of a terminal condition, under the [Rights of the Terminally Ill Act](#). You can create a Living Will using the form in the statute, listed below, or you may create your own form if it meets the legal requirements of the Act.

- [Living Will Declaration Form](#)

3. RI MOLST: Medical Orders for Life-Sustaining Treatment

Medical Orders for Life Sustaining Treatment (MOLST) are instructions to follow a terminally ill patient's wishes regarding resuscitation, feeding tubes and other life-sustaining medical

treatments. The MOLST form is voluntary. Adults diagnosed with medical frailty or a serious illness can choose to complete a MOLST form with their clinicians. Clinicians and patients talk about prognosis, treatment options and what the patient chooses for life-sustaining treatments. The clinician translates an adult's wishes onto the MOLST form so all clinicians can know and honor an individual's care choices. Read more about how RI MOLST works [here](#).

- RI MOLST
 - [English](#)
 - [Spanish](#)

National POLST

Rhode Island is part of [National POLST](#), a 47-state collective that provides helpful information, videos and tools about serious illness and POLST/MOLST forms. Read more [here](#). For information or to ask questions, contact RI Plenary Assembly Members: Terry Rochon, Trochon@vnacarenewengland.org and Kelly Baxter, kebaxter25@gmail.com

Resources

Here are additional resources to access planning information, care and services:

- [Healthcentric Advisors; My Care, My Choice, My Voice](#)
- [Age Friendly RI](#)
- [Rhode Island Office of Healthy Aging](#)
- [VNA Care New England](#)
- [MLPB COVID-19 Digital Digest](#)
- [State of RI, Department of Health; Advanced Directives](#)
- [National POLST](#)

RI Partners

Thank you to our RI Partners for their guidance in developing this tool kit. We are working together to provide free planning documents, improve cross-state services, and ensure all RI residents can access timely, equitable care.

- [Therese Rochon](#), MS, MA, FNP-C, ACHPN, Director, Community Based Palliative Care, VNA Care New England
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- [Nelia Odom](#), Healthcentric Advisors
- [Jeannine Casselman](#), Esq., Legal Director, MLPB, RI Digital Digest,
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Durable Power of Attorney for Healthcare Statutory Form

WARNING TO PERSON EXECUTING THIS DOCUMENT

This is an important legal document which is authorized by the general laws of this state. Before executing this document, you should know these important facts:

You must be at least eighteen (18) years of age and a resident of the state for this document to be legally valid and binding.

This document gives the person you designate as your agent (the attorney in fact) the power to make healthcare decisions for you. Your agent must act consistently with your desires as stated in this document or otherwise made known.

Except as you otherwise specify in this document, this document gives your agent the power to consent to your doctor not giving treatment or stopping treatment necessary to keep you alive.

Notwithstanding this document, you have the right to make medical and other healthcare decisions for yourself so long as you can give informed consent with respect to the particular decision. In addition, no treatment may be given to you over your objection at the time, and healthcare necessary to keep you alive may not be stopped or withheld if you object at the time.

This document gives your agent authority to consent, to refuse to consent, or to withdraw consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. This power is subject to any statement of your desires and any limitation that you include in this document. You may state in this document any types of treatment that you do not desire. In addition, a court can take away the power of your agent to make healthcare decisions for you if your agent:

- (1) Authorizes anything that is illegal,
- (2) Acts contrary to your known desires, or
- (3) Where your desires are not known, does anything that is clearly contrary to your best interests.

Unless you specify a specific period, this power will exist until you revoke it. Your agent's power and authority ceases upon your death except to inform your family or next of kin of your desire, if any, to be an organ and tissue owner.

You have the right to revoke the authority of your agent by notifying your agent or your treating doctor, hospital, or other healthcare provider orally or in writing of the revocation.

Your agent has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document. This document revokes any prior durable power of attorney for healthcare.

You should carefully read and follow the witnessing procedure described at the end of this form. This document will not be valid unless you comply with the witnessing procedure.

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you.

Your agent may need this document immediately in case of an emergency that requires a decision concerning your healthcare. Either keep this document where it is immediately available to your agent and alternate agents or give each of them an executed copy of this document. You may also want to give your doctor an executed copy of this document.

(1) DESIGNATION OF HEALTHCARE AGENT. I, (insert your name and address below)

First Name

Middle Name

Last Name

Address: _____
City/State/Zip

Do hereby designate and appoint:

(insert name, address, and telephone number of one individual only as your agent to make healthcare decisions for you. None of the following may be designated as your agent:

(1) your treating healthcare provider, (2) a nonrelative employee of your treating healthcare provider, (3) an operator of a community care facility, or (4) a nonrelative employee of an operator of a community care facility.) as my attorney in fact (agent) to make healthcare decisions for me as authorized in this document. For the purposes of this document, "healthcare decision" means consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat an individual's physical or mental condition.)

Name: _____ Address: _____

Phone: _____ City/State/Zip

(2) CREATION OF DURABLE POWER OF ATTORNEY FOR HEALTHCARE. By this document I intend to create a durable power of attorney for healthcare.

(3) GENERAL STATEMENT OF AUTHORITY GRANTED. Subject to any limitations in this document, I hereby grant to my agent full power and authority to make healthcare decisions for me to the same extent that I could make such decisions for myself if I had the capacity to do so. In exercising this authority, my agent shall make healthcare decisions that are consistent with my desires as stated in this document or otherwise made known to my agent, including, but not limited to, my desires concerning obtaining or refusing or withdrawing life-prolonging care, treatment, services, and procedures and informing my family or next of kin of my desire, if any, to be an organ or tissue donor.

(If you want to limit the authority of your agent to make healthcare decisions for you, you can state the limitations in paragraph (4) ("Statement of Desires, Special Provisions, and Limitations") below. You can indicate your desires by including a statement of your desires in the same paragraph.)

(4) STATEMENT OF DESIRES, SPECIAL PROVISIONS, AND LIMITATIONS. (Your agent must make healthcare decisions that are consistent with your known desires. You can, but are not required to, state your desires in the space provided below. You should consider whether you want to include a statement of your desires concerning life-prolonging care, treatment, services, and procedures. You can also include a statement of your desires concerning other matters relating to your healthcare. You can also make your desires known to your agent by discussing your desires with your agent or by some other means. If there are any types of treatment that you do not want to be used, you should state them in the space below. If you want to limit in any other way the authority given your agent by this document, you should state the limits in the space below. If you do not state any limits, your agent will have broad powers to make healthcare decisions for you, except to the extent that there are limits provided by law.)

In exercising the authority under this durable power of attorney for healthcare, my agent shall act consistently with my desires as stated below and is subject to the special provisions and limitations stated below:

(a) Statement of desires concerning life-prolonging care, treatment, services, and procedures:

(b) Additional statement of desires, special provisions, and limitations regarding healthcare decisions:

(c) Statement of desire regarding organ and tissue donation:

Initial if applicable:

In the event of my death, I request that my agent inform my family/next of kin of my desire to be an organ and tissue donor, if possible.

(You may attach additional pages if you need more space to complete your statement. If you attach additional pages, you must date and sign EACH of the additional pages at the same time you date and sign this document.)

(5) INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH. Subject to any limitations in this document, my agent has the power and authority to do all of the following:

- (a) Request, review, and receive any information, verbal or written, regarding my physical or mental health, including, but not limited to, medical and hospital records.
- (b) Execute on my behalf any releases or other documents that may be required in order to obtain this information.
- (c) Consent to the disclosure of this information.

(If you want to limit the authority of your agent to receive and disclose information relating to your health, you must state the limitations in paragraph (4) ("Statement of desires, special provisions, and limitations") above.)

(6) SIGNING DOCUMENTS, WAIVERS, AND RELEASES. Where necessary to implement the healthcare decisions that my agent is authorized by this document to

make, my agent has the power and authority to execute on my behalf all of the following:

- (a) Documents titled or purporting to be a "Refusal to Permit Treatment" and "Leaving Hospital Against Medical Advice."
- (b) Any necessary waiver or release from liability required by a hospital or physician.

(7) DURATION. (Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.)

This durable power of attorney for healthcare expires on: _____

(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)

(8) DESIGNATION OF ALTERNATE AGENTS. (You are not required to designate any alternate agents but you may do so. Any alternate agent you designate will be able to make the same healthcare decisions as the agent you designated in paragraph (1), above, in the event that agent is unable or ineligible to act as your agent. If the agent you designated is your spouse, he or she becomes ineligible to act as your agent if your marriage is dissolved.)

If the person designated as my agent in paragraph (1) is not available or becomes ineligible to act as my agent to make a healthcare decision for me or loses the mental capacity to make healthcare decisions for me, or if I revoke that person's appointment or authority to act as my agent to make healthcare decisions for me, then I designate and appoint the following persons to serve as my agent to make healthcare decisions for me as authorized in this document, such persons to serve in the order listed below:

(A) First Alternate Agent: (Insert name, address, and telephone number of first alternate agent.)

(B) Second Alternate Agent: (Insert name, address, and telephone number of second alternate agent.)

(9) PRIOR DESIGNATIONS REVOKED. I revoke any prior durable power of attorney for healthcare.

DATE AND SIGNATURE OF PRINCIPAL (YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Statutory Form Durable Power of Attorney for Healthcare on _____ (Enter date) at
(Enter City) (Enter State)

(You sign below)

(THIS POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS SIGNED BY ONE NOTARY PUBLIC OR TWO (2) QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE. IF YOU HAVE ATTACHED ANY ADDITIONAL PAGES TO THIS FORM, YOU MUST DATE AND SIGN EACH OF THE ADDITIONAL PAGES AT THE SAME TIME YOU DATE AND SIGN THIS POWER OF ATTORNEY.)

STATEMENT OF WITNESSES

(This document must be witnessed by two (2) qualified adult witnesses or one (1) notary public. None of the following may be used as a witness:

- (1) A person you designate as your agent or alternate agent,
- (2) A healthcare provider,
- (3) An employee of a healthcare provider,
- (4) The operator of a community care facility,
- (5) An employee of an operator of a community care facility.

I declare under penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a healthcare provider, an employee of a healthcare provider, the operator of a community care facility, nor an employee of an operator of a community care facility.

Option 1 – Two (2) Qualified Witnesses:

Signature:

Residence Address:

Print Name:

Date:

Signature:

Residence Address:

Print Name:

Date:

Option 2 – One Notary Public Signature

Signature:

, Notary Public

Print Name:

Date:

My commission expires on:

(AT LEAST ONE OF THE ABOVE WITNESSES OR THE NOTARY PUBLIC MUST ALSO SIGN THE FOLLOWING DECLARATION.)

I further declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature:

Print Name:

Rhode Island Durable Power Of Attorney For Health Care

AN ADVANCE CARE DIRECTIVE

“A GIFT OF PREPAREDNESS”



INTRODUCTION

YOUR RIGHTS

Adults have the fundamental right to control the decisions relating to their health care. You have the right to make medical and other health care decisions for yourself so long as you can give informed consent for those decisions. No treatment may be given to you over your objection at the time of treatment. You may decide whether you want life sustaining procedures withheld or withdrawn in instances of a terminal condition.

What is a Durable Power of Attorney for Health Care?

This Durable Power of Attorney for Health Care lets you appoint someone to make health care decisions for you when you cannot actively participate in health care decision making. The person you appoint to make health care decisions for you when you cannot actively participate in health care decision making is called your agent. The agent must act consistent with your desires as stated in this document or otherwise known. Your agent must act in your best interest. Your agent stands in your place and can make any health care decision that you have the right to make.

You should read this Durable Power of Attorney for Health Care carefully. Follow the witnessing section as required. To have your wishes honored, this Durable Power of Attorney for Health Care must be valid.

REMEMBER

- You must be at least eighteen (18) years old.
- You must be a Rhode Island resident.
- You should follow the instructions on this Durable Power of Attorney for Health Care.
- You must voluntarily sign this Durable Power of Attorney for Health Care.
- You must have this Durable Power of Attorney for Health Care witnessed properly.
- No special form must be used but if you use this form it will be recognized by health care providers.
- Make copies of your Durable Power of Attorney for Health Care for your agent, alternative agent, physicians, hospital, and family.
- Do not put your Durable Power of Attorney for Health Care in a safe deposit box.
- Although you are not required to update your Durable Power of Attorney for Health Care, you may want to review it periodically.

Commonly Used Life-Support Measures Are Listed on the Back Inside Page

**DURABLE POWER OF ATTORNEY FOR HEALTH CARE
(RHODE ISLAND HEALTH CARE ADVANCE DIRECTIVE)**

I, _____,
(Insert your name and address)

am at least eighteen (18) years old, a resident of the State of Rhode Island, and understand this document allows me to name another person (called the health care agent) to make health care decisions for me if I can no longer make decisions for myself and I cannot inform my health care providers and agent about my wishes for medical treatment.

**PART I: APPOINTMENT OF HEALTH CARE AGENT
THIS IS WHO I WANT TO MAKE HEALTH CARE DECISIONS
FOR ME IF I CAN NO LONGER MAKE DECISIONS**

Note: You may not appoint the following individuals as an agent:

- (1) your treating health care provider, such as a doctor, nurse, hospital, or nursing home,*
- (2) a nonrelative employee of your treating health care provider,*
- (3) an operator of a community care facility, or*
- (4) a nonrelative employee of an operator of a community care facility.*

When I am no longer able to make decisions for myself, I name and appoint _____ to make health care decisions for me. This person is called my health care agent.

Telephone number of my health care agent: _____

Address of my health care agent: _____

You should discuss this health care directive with your agent and give your agent a copy.

(OPTIONAL)

APPOINTMENT OF ALTERNATE HEALTH CARE AGENTS:

You are not required to name alternative health care agents. An alternative health care agent will be able to make the same health care decisions as the health care agent named above, if the health care agent is unable or ineligible to make health care decisions for you. For example, if you name your spouse as your health care agent and your marriage is dissolved, then your former spouse is ineligible to be your health care agent.

When I am no longer able to make decisions for myself and my health care agent is not available, not able, loses the mental capacity to make health care decisions for me, becomes ineligible to act as my agent, is not willing to make health care decisions for me, or I revoke the person appointed as my agent to make health care decisions for me, I name and appoint the following persons as my agent to make health care decision for me as authorized by this document, in the order listed below:

My First Alternative Health Care Agent : _____

Telephone number of my first alternative health care agent: _____

Address of my first alternative health care agent: _____

My Second Alternative Health Care Agent : _____

Telephone number of my second alternative health care agent: _____

Address of my second alternative health care agent: _____

My health care agent is automatically given the powers I would have to make health care decisions for me if I were able to make such decisions. Some typical powers of a health care agent are listed below in (A) through (H). My health care agent must convey my wishes for medical treatment contained in this document or any other instructions I have given to my agent. If I have not given health care instructions, then my agent must act in my best interest. A court can take away the power of an agent to make health care decisions for you if your agent:

- (1) Authorizes anything illegal,*
- (2) Acts contrary to your known wishes, or*
- (3) Where your desires are not known, does anything that is clearly contrary to your best interest.*

Whenever I can no longer make decisions about my medical treatment, my health care agent has the power to:

- (A) Make any health care decision for me. This includes the power to give, refuse, or withdraw consent to any care, treatments, services, tests, or procedures. This includes deciding whether to stop or not start health care that is keeping me or might keep me alive, and deciding about mental health treatment.
- (B) Advocate for pain management for me.
- (C) Choose my health care providers, including hospitals, physicians, and hospice.
- (D) Choose where I live and receive health care which may include residential care, assisted living, a nursing home, a hospice, and a hospital.
- (E) Review my medical records and disclose my health care information, as needed.
- (F) Sign releases or other documents concerning my medical treatment.
- (G) Sign waivers or releases from liability for hospitals or physicians.
- (H) Make decisions concerning participation in research.

If I DO NOT want my health care agent to have a power listed above in (A) through (H) OR if I want to LIMIT a power in (A) through (H), I must say that here:

_____ **My Initials**

PART II: HEALTH CARE INSTRUCTIONS

THIS IS WHAT I WANT AND DO NOT WANT FOR MY HEALTH CARE

Many medical treatments may be used to try to improve my medical condition in certain circumstances or to prolong my life in other circumstances. Many medical treatments can be started and then stopped if they do not help. Examples include artificial breathing by a machine connected to a tube in the lungs, artificial feeding or fluids through tubes, attempts to start the heart, surgeries, dialysis, antibiotics, and blood transfusions. The back inside page has more information about life-support measures.

OPTIONAL -FOR DISCUSSION PURPOSES

A discussion of these questions with your health care agent may help him or her make health care decisions for you which reflect your values when you cannot make those decisions.

These are my views which may help my agent make health care decisions:

1. Do you think your life should be preserved for as long as possible? Why or why not?

2. Would you want your pain managed, even if it makes you less alert or shortens your life?

3. Do your religious beliefs affect the way you feel about death? Would you prefer to be buried or cremated?

4. Should financial considerations be important when making a decision about medical care?

5. Have you talked with your agent, alternative agent, family and friends about these issues?

Here are my desires about my health care to guide my agent and health care providers.

1. If I am close to death and life support would only prolong my dying:

INITIAL ONLY ONE:

- _____ I want to receive a feeding tube.
_____ I DO NOT WANT a feeding tube.

INITIAL ONLY ONE:

- _____ I want all life support that may apply.
_____ I want NO life support.

2. If I am unconscious and it is very unlikely that I will ever become conscious again:

INITIAL ONLY ONE:

- _____ I want to receive a feeding tube.
_____ I DO NOT WANT a feeding tube.

INITIAL ONLY ONE:

- _____ I want all other life support that may apply.
_____ I want NO life support.

3. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

INITIAL ONLY ONE:

- _____ I want to receive a feeding tube.
_____ I DO NOT WANT a feeding tube.

INITIAL ONLY ONE:

- _____ I want all life support that may apply.
_____ I want NO life support.

Additional statement of desires, special provisions, and limitations regarding health care decisions (*More space is available on page 8*):

ORGAN DONATION

_____ In the event of my death, I request that my agent inform my family or next of kin of my desire to be an organ and tissue donor for **transplant**. (*Initial if applicable*)

_____ In the event of my death, I request that my agent inform my family or next of kin of my desire to be an organ and tissue donor for **research**. (*Initial if applicable*)

RELIGIOUS AND SPIRITUAL REQUESTS

Do you want your Rabbi, Priest, Clergy, Minister, Imam, Monk, or other spiritual advisor contacted if you become sick?

INITIAL ONLY ONE:

_____ Yes _____ No

Name of Rabbi, Priest, Clergy, Minister, Imam, Monk, or other spiritual advisor:

Address: _____

Phone Number: _____

DURATION

Unless you specify a shorter period in the space below, this power of attorney will exist until it is revoked.

I do not want this durable power of attorney for health care to exist until revoked. I want this durable power of attorney for health care to expire on _____

(Fill in this space ONLY if you want the authority of your agent to end on a specific date.)

REVOCACTION

I can revoke this Durable Power of Attorney for Health Care at any time and for any reason either in writing or orally. If I change my agent or alternative agents or make any other changes, I need to complete a new Durable Power of Attorney for Health Care with those changes.

PART III: MAKING THE DOCUMENT LEGAL

I revoke any prior designations, advance directives, or durable power of attorney for health care.

Date and Signature of Principal

I am thinking clearly, I agree with everything that is written in this document, and I have made this document willingly.

Signature

Date signed:

_____ **My Initials**

DATE AND SIGNATURES OF TWO QUALIFIED WITNESSES OR ONE NOTARY PUBLIC

Two qualified witnesses or one notary public must sign the durable power of attorney for health care form at the same time the principal signs the document. The witnesses must be adults and must not be any of the following:

- (1) a person you designate as your agent or alternate agent,**
- (2) a health care provider,**
- (3) an employee of a health care provider,**
- (4) the operator of a community care facility, or**
- (5) an employee of an operator of a community care facility.**

I declare under the penalty of perjury that the person who signed or acknowledged this document is personally known to me to be the principal, that the principal signed or acknowledged this durable power of attorney for health care in my presence, that the principal appears to be of sound mind and under no duress, fraud, or undue influence, that I am not the person appointed as attorney in fact by this document, and that I am not a health care provider, an employee of a health care provider, the operator of a community care facility, or an employee of an operator of a community care facility.

OPTION ONE:

Signature: _____
Print Name: _____
Residence Address: _____
Date: _____

Signature: _____
Print Name: _____
Residence Address: _____
Date: _____

-----OR-----

OPTION TWO:

Signature of Notary Public: _____
Print Name: _____
Commission Expires: _____
Business Address: _____
Date: _____

TWO QUALIFIED WITNESSES OR ONE NOTARY PUBLIC DECLARATION

At least one of the qualified witnesses or the notary public must make this additional declaration:

I further declare under penalty of perjury that I am not related to the principal by blood, marriage, or adoption, and, to the best of my knowledge, I am not entitled to any part of the estate of the principal upon the death of the principal under a will now existing or by operation of law.

Signature: _____

Print Name: _____

Signature: _____

Print Name: _____

PART IV: DISTRIBUTING THE DOCUMENT

You are not required to give anyone your Durable Power of Attorney for Health Care, but if it cannot be found at the time you need it, it cannot help you. For example, you are unable to participate in making health care decisions and your Durable Power of Attorney for Health Care is a safe deposit box, the agent, physician and other health care providers will not have access to it and they will not be able to respect your medical treatment wishes. You may want to give a copy of your Durable Power of Attorney for Health Care to some or all of the persons listed below so that it can be available when you need it.

- | | (Name) | (Address) | (Phone) |
|---|--------|-----------|---------|
| <input type="checkbox"/> Health Care Agent | _____ | _____ | _____ |
| <input type="checkbox"/> First Alternative Health Care Agent | _____ | _____ | _____ |
| <input type="checkbox"/> Second Alternative Health Care Agent | _____ | _____ | _____ |
| <input type="checkbox"/> Physician | _____ | _____ | _____ |
| <input type="checkbox"/> Family | _____ | _____ | _____ |
| <input type="checkbox"/> Lawyer | _____ | _____ | _____ |
| <input type="checkbox"/> Others | _____ | _____ | _____ |

COMMONLY USED LIFE-SUPPORT MEASURES

Cardiopulmonary Resuscitation (CPR)

Cardiopulmonary resuscitation (CPR) is a group of treatments used when someone's heart and/or breathing stops. CPR is used in an attempt to restart the heart and breathing. It may consist only of mouth-to-mouth breathing or it can include pressing on the chest to mimic the heart's function and cause blood to circulate. Electric shock and drugs also are used frequently to stimulate the heart.

When used quickly in response to a sudden event like a heart attack or drowning, CPR can be life-saving. But the success rate is extremely low for people who are at the end of a terminal disease process. Critically ill patients who receive CPR have a small chance of recovering or leaving the hospital.

Rhode Islanders with a terminal condition who do not want rescue/ambulance service/emergency medical services personnel to perform CPR may join COMFORT ONE. Rescue/ambulance/emergency workers will provide comfort measures but will not perform CPR or any resuscitation. To join COMFORT ONE, speak to your physician. ONLY your physician can enroll you in the COMFORT ONE PROGRAM. Your physician writes a medical order directing rescue/ambulance service/emergency personnel not to start CPR which is filed with the Rhode Island Department of Health.

Mechanical Ventilation

Mechanical ventilation is used to help or replace how the lungs work. A machine called a ventilator (or respirator) forces air into the lungs. The ventilator is attached to a tube inserted in the nose or mouth and down into the windpipe (or trachea). Mechanical ventilation often is used to assist a person through a short-term problem or for prolonged periods in which irreversible respiratory failure happens due to injuries to the upper spinal cord or a progressive neurological disease.

Some people on long-term mechanical ventilation are able to enjoy themselves and live a quality of life that is important to them. For the dying patient, however, mechanical ventilation often merely prolongs the dying process until some other body system fails. It may supply oxygen, but it cannot improve the underlying condition.

When discussing end-of-life wishes, make clear to loved ones and your physician whether you would want mechanical ventilation if you would never regain the ability to breathe on your own or return to a quality of life acceptable to you.

Artificial Nutrition and Hydration

Artificial nutrition and hydration (or tube feeding) supplements or replaces ordinary eating and drinking by giving a chemically balanced mix of nutrients and fluid through a tube placed directly into the stomach, the upper intestine, or a vein. Artificial nutrition and hydration can save lives when used until the body heals.

Long-term artificial nutrition and hydration may be given to people with serious intestinal disorders that impair their ability to digest food, thereby helping them to enjoy a quality of life that is important to them. Sometimes long-term use of tube feeding frequently is given to people with irreversible and end-stage conditions which will not reverse the course of the disease itself or improve the quality of life. Some health care facilities and physicians may not agree with stopping or withdrawing tube feeding. You may want to talk with your loved ones and physician about your wishes for artificial nutrition and hydration in your Durable Power of Attorney for Health Care.