# Advance Directives

**A PERSONAL DECISION**

Practical information about determining
your future medical care
including declaration,
powers of attorney for health care
and organ donation

# Determining Your Medical Care is Your Right

While advances in medicine and medical technology can save many lives that only fifty years ago might have been lost, the issue of quality at the end of life has come under intensive judicial and public scrutiny. In the state of Nevada, it is your legal right at all times to determine the degree and kind of care you wish to receive. This includes your right to consent to or refuse medical care and treatment as long as you are capable to do so. You can also decide today and direct your health care providers and family about the care you want in the event of an illness or injury including terminal illness, if you are unable then to make these decisions. You can decide today if you want procedures such as artificial breathing and kidney treatments, feeding through a tube or a vein, among others, if they would only prolong the process of dying and do no more than delay your death.
Decisions about the quality of the end of life—about life support systems, aggressive resuscitation efforts, about hydration and nutrition of comatose patients—are all serious, personal decisions each of us must arrive at privately. Neither the law nor any person can require you to make such a decision against your will. If you wish to exercise your right to determine the care you receive should you be injured or ill, this brochure will help you make an informed decision.

**449.620 Revocation of declaration; immunity when revocation of declaration not followed.**

A declaration may be revoked at any time by the declarant in the same way in which a will may be revoked, or by an oral expression of intent to revoke. An oral revocation is effective upon communication to the attending physician by the declarant or another person communicating it on behalf of the declarant. The attending physician shall record the oral revocation and the date on which he received it in the medical record of the declarant. No person is liable in a civil or criminal action for failure to act upon a revocation of a declaration unless the person had actual knowledge of the revocation. (Added to NRS by 1977.760; A 1987,1309; 1991,635)

**449.630 Immunity when life-sustaining procedures are withheld or withdrawn.**

No hospital or other medical facility, physician or person working under the direction of a physician who causes the withholding or withdrawal of life sustaining procedures from a patient in a terminal condition who has a declaration in effect and has become comatose or has otherwise been rendered incapable of communicating with his attending physician is subject to criminal or civil liability or to a charge of unprofessional conduct or malpractice as a result of an action taken in accordance with NRS 449.600 to 499.660, inclusive. (Added to NRS by 1977.760; A 1985.1747; 1991,635)

### *How to Indicate Your Decisions*

In Nevada two documents are available for your use in directing your health care when you are incapable to do so: the durable power of attorney for health care and the Declaration will. You can use either or both of these documents or you may write out your wishes and directives. The choice is yours and you can change your mind at any time.

### *Durable Power of Attorney for Health Care*

In the state of Nevada the best way to assure that your instructions about your health care are followed is through the use of a durable power of attorney for health care. Using this document you can designate someone else, called an agent or surrogate, to make decisions about your health care in the event you are unable to do so yourself. This person can, by law, be anyone you choose over the age of 18 (not 21) except the doctor providing your care. This person will have the legal right and responsibility to make decisions about your health care, including the initiation and termination of medical procedures and life support systems, organ donation and autopsy. For example, a person with irreversible brain injuries remains in a coma from which doctors have determined the patient will never recover. The agent designated in the durable power of attorney for health care can refuse the antibiotic treatment that the hospital would administer should the patient develop pneumonia. Without antibiotics, the pneumonia would most likely be fatal. Because the patient has determined—in advance, through discussion with surrogates and by signing the durable power of attorney—that death should not be delayed in this circumstance, the agent is authorized to decline lifesaving efforts. Most people select a member of their family or a close friend to act as their surrogate in these situations. You may designate several surrogates, in case your first choice of a decision-maker is unavailable or unwilling to serve. Whoever you choose, you should discuss your wishes with them. While your caregivers must respect your surrogate's decisions and the court will uphold them, the surrogate or agent can be removed by the court if doing so is determined to be in your best interest. Your physician and the hospital will also play a part in that decision. This booklet includes a Durable Power of Attorney for Health Care, legal in the state of Nevada. This form is not required but it is the surest way to meet all the specifications of Nevada law. If you decide to execute the durable power of attorney, be sure to inform your doctor, the hospital and your family. Keep the form in a safe place and let someone you trust know where it is.

### *Declaration (Living Will)*

The declaration (living will) does not appoint another person to make your health care decisions but declares your intent that if your medical condition is incurable and irreversible, the people taking care of you not delay your death, if it is imminent, through lifesaving measures. It allows you to control your health care even if you cannot communicate with the people caring for you. For example, a cancer patient whom the doctors estimate has only weeks to live can, through the use of a declaration, instruct the hospital that no extraordinary measures are to be taken to prolong her life; if she suffers cardiac arrest, for example, the hospital is not to attempt to revive her. She may also choose to decline the future use of a respirator, or techniques such as blood transfusion or kidney dialysis. Any adult (over the age of 18) of sound mind can make a declaration. It must be created as a voluntary act must be signed by a patient (or another person at the direction of the patient) and must be witnessed by two adults. The declaration has no effect legally unless the physician responsible for the patient's care certifies, in writing, that the patient's condition is terminal, that death is imminent, and that death-delaying procedures will only prolong the process of dying. Nutrition and hydration may not be withheld or withdrawn if such act, and not the existing medical condition, will cause death. Following is a Declaration (Living Will) form.

The following is the form of a “Declaration,” provided for under Nevada Statutes:

# DECLARATION

If I should have an incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of my attending physician, cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct any attending physician, pursuant to NRS 449.535 to 449.690, inclusive, to withhold or withdraw treatment that only prolongs the process of dying and is not necessary for my comfort or to alleviate pain.

If you wish to include the following statement in this declaration, you must INITIAL the statement in the box provided:

> Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. Initial this box if you want to receive or continue receiving artificial nutrition and hydration by way of the gastrointestinal tract after all other treatment is withheld pursuant to this declaration .....[ _____]

Signed this _____day of _____, 20_____.

Signature: _____

Address:_____

_____

_____

The declarant voluntarily signed this writing in my presence.

Witness:_____

Address:_____

Witness:_____

Address:_____

The following is the form of a “Durable Power of Attorney for HealthCare Decisions” provided for under Nevada Statutes 449.800-449.860.

## Durable Power of Attorney for HealthCare Decisions
## Warning to Person Executing this Document

This is an important legal document. It creates a Durable Power of Attorney for HealthCare. Before executing this document, you should know these important facts.

1. This document gives the person you designate as your Attorney-in-Fact the power to make health care decisions for you. This power is subject to any limitations or statement of your desires that you include in this document. The power to make health care decisions for you may include consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition. You may state in this document any types of treatment or placements that you do not desire.

2. The person you designate in this document has a duty to act consistent with your desires as stated in this document or otherwise made known or, if your desires are unknown, to act in your best interests.

3. Except as you otherwise specify in this document, the power of the person you designate to make health care decisions for you may include the power to consent to your doctor not giving treatment or stopping treatment which would keep you alive.

4. Unless you specify a shorter period in this document, this Power will exist indefinitely from the date you execute this document and if you are unable to make health care decisions for yourself, this power will continue to exist until the time when you become able to make health care decisions for yourself.

5. Notwithstanding this document, you have the right to make medical and other health care 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, and health care necessary to keep you alive may not be stopped if you object.

6. You have the right to revoke the appointment of the person designated in this document to make health care decisions for you by notifying that person of the revocation orally or in writing.

7. You have the right to revoke the authority granted to the person designated in this document to make health care decisions for you by notifying the treating physician, hospital, or other provider of health care orally or in writing.

8. The person designated in this document to make health care decisions for you has the right to examine your medical records and to consent to their disclosure unless you limit this right in this document.

9. This document revokes any prior Durable Power of Attorney for HealthCare.

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

***1. Designation of HealthCare Agent***

_____(insert your name) do hereby and appoint:

Name:_____

Address:

_____

Telephone
Number:_____

as my attorney-in-fact to make health care decisions for me as authorized in this document.
(Insert the name and address of the person you wish to designate as your attorney-in-fact to make health care decisions for you. Unless the person is also your spouse, legal guardian or the person most closely related to you by blood, none of the following may be designated as your attorney-in-fact: (1) your treating provider of health care; (2) an employee of your treating provider of health care; (3) an operator of a health care facility; or (4) an employee of an operator of a health care facility.)

***2. Creation of Durable Power of Attorney for Health Care***

By this document, I intend to create a Durable Power of Attorney by appointing the person designated above to make health care decisions for me. This power of attorney shall not be affected by my subsequent incapacity.

**3**. ***General Statement of Authority Granted***

In the event that I am incapable of giving informed consent with respect to health care decisions, I hereby grant to the attorney-in-fact named above full power, and authority to make health care decisions for me before, or after my death, including: consent, refusal of consent, or withdrawal of consent to any care, treatment, service, or procedure to maintain, diagnose, or treat physical or mental condition, subject only to the limitations and special provisions, if any, set forth in paragraph 4 or 6.

***4. Special Provisions and Limitations***

(Your attorney-in-fact is not permitted to consent to any of the following: commitment to or placement in a mental health treatment facility, convulsive treatment, psychosurgery, sterilization, or abortion. If there are any other types of treatment or placement that you do not want your attorney-in-fact's authority to give consent for or other restrictions you wish to place on your attorney-in-fact's authority, you should list them in the space below. If you do not write any limitation, your attorney-in-fact will have the broad powers to make health care decisions on your behalf which are set forth in paragraph 3, except to the extent that there are limits provided by law.)

In exercising the authority under this Durable Power of Attorney for HealthCare, the authority of my attorney in-fact is subject to the following special provisions and limitations:

_____

_____

_____

_____

***5. Duration***

I understand that this power of attorney will exist indefinitely from the date I execute this document unless I establish a shorter time. If I am unable to make health care decision for myself when this Power of Attorney expires, the authority I have granted my attorney-in-fact will continue to exist until the time when I become able to make health care decisions for myself
(If Applicable)

I wish to have the Power of Attorney end on the following date: _____

***6. Statement of Desires***

(With respect to decisions to withhold or withdraw life-sustaining treatment, your attorney-in-fact must make health care decisions that are consistent with your known desires. You can, but are not required to, indicate your desires below. If your desires are unknown, your attorney-in-fact has the duty to act in your best interests; and, under some circumstances, a judicial proceeding may be necessary so that a court can determine the health care decisions that are in your best interests. If you wish to indicate your desires, you may INITIAL the statement or statements that reflect your desires and/or write your own statements in the space below.)
(If the statement reflects your desires, initial the box next to the statement.)

1. I desire that my life be prolonged to the greatest extent possible, without regard to my condition, the chances I have for recovery or long-term survival, or the cost of the procedures.....[_____]

2. If I am in a coma which my doctors have reasonably concluded is irreversible, I desire that life-sustaining or prolonging treatment not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, if this subparagraph is initialed .....[_____]

3. If I have an incurable or terminal condition or illness and no reasonable hope of long-term recovery or survival, I desire that life-sustaining or prolonging treatments not be used. (Also should utilize provisions of NRS 449.535 to 449.690, inclusive, and section 2 to 12, inclusive, if this subparagraph is initialed.....[_____]

4. Withholding or withdrawal of artificial nutrition and hydration may result in death by starvation or dehydration. I want to receive or continue receiving artificial nutrition and hydration by way of the gastrointestinal tract after all other treatment is withheld .....[_____]

5. I do not desire treatment to be provided and/or continue if the burdens of the treatment outweigh the expected benefits. My attorney-in-fact is to consider the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of the possible extension of my life.....[_____]

(If you wish to change your answer, you may do so by drawing an “X” through the answer you do not want, and circling the answer you prefer.)
Other or Additional Statements of Desires:_____

_____

_____

_____

_____

**7. *Designation of Alternate Attorney-in-Fact***

(You are not required to designate any alternative attorney-in-fact but you may do so. Any alternative attorney-in-fact you designate will be able to make the same health care decisions as the attorney-in-fact designated in paragraph 1 to act as your attorney-in-fact. Also, if the attorney-in-fact designated in paragraph 1 is your spouse, his or her designation as your attorney-in-fact is automatically revoked by law if your marriage is dissolved.)

If the person designated in paragraph 1 as my attorney-in-fact is unable to make health care decisions for me, then I designate the following persons to serve as my attorney-in-fact to make health care decisions for me as authorized in this document, such persons to serve in the order listed below:

A. First Alternative Attorney-in-Fact

Name: _____

Address:_____

_____

Telephone: _____

B. Second Alternative Attorney-in-Fact

Name: _____

Address:_____

_____

Telephone Number: _____

***8. Prior Designations Revoked***

I revoke any prior Durable Power of Attorney for Health Care:
(YOU MUST DATE AND SIGN THIS POWER OF ATTORNEY)

I sign my name to this Durable Power of Attorney for Health Care on_____(date)

at _____(city), _____(state).

_____
(Signature)

(THIS POWER OF ATTORNEY WILL NOT BE VALID FOR MAKING HEALTH CARE DECISIONS UNLESS IT IS EITHER (1) SIGNED BY AT LEAST TWO QUALIFIED WITNESSES WHO ARE PERSONALLY KNOWN TO YOU AND WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE, OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.)

## Certificate of Acknowledgment of Notary Public

(You may use acknowledgment before a notary public instead of statement of witnesses.)

State of Nevada )

: ss:

County of _____)

On this _____day of _____, in the Year_____,

before me, _____(here insert name of notary public) personally

appeared _____(here insert name of principal) personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this instrument, and acknowledged that he or she executed it. I declare under penalty of perjury that the person whose name is ascribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

**NOTARY SEAL**

_____
(Signature of Notary Public)

# STATEMENT OF WITNESSES

(You should carefully read and follow this witnessing procedure. This document will not be valid unless you comply with the witnessing procedure. If you elect to use witnesses instead of having this document notarized, you must use two qualified adult witnesses. None of the following may be used as a witness: (1) a person you designate as the attorney-in-fact; (2) a provider of health care; (3) an employee of a provider of health care; (4) the operator of a health care facility; (5) an employee of an operator of a health care facility. At least one of the witnesses must make the additional declaration set out following the place where the witnesses sign.)

I declare under penalty of perjury that the principal is personally known to me, that the principal signed or acknowledged the 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 provider of health care, an employee of a provider of health care, the operator of a community care facility, nor an employee of an operator of a health care facility.

Signature: _____

Print Name: _____

Residence Address: _____

_____

Date: _____

Signature: _____

Print Name: _____

Residence Address: _____

_____

Date: _____

**(AT LEAST ONE OF THE ABOVE WITNESSES MUST ALSO SIGN THE FOLLOWING DECLARATION.)**

I 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: _____

Signature: _____

Names: _____ Address:_____

Print Name: _____ _____

Date: _____ _____

**COPIES:** You should retain an executed copy of this document and give one to your attorney-in-fact. The power of attorney should be available so a copy may be given to your providers of health care.
Under NRS 449.628, a health care provider is allowed to transfer care of a patient to another provider if the first provider objects on the basis of conscience to implementation of an advance directive.

# Organ Donation

***Our Final and Best Gift***

Advances in medical technology over the past twenty years have allowed physicians to save lives, restore health and bring the gift of vision through the gift of organ donation.

Organ donation will occur only after everything has been done to save the donor's life and after death has been declared; the procedure is surgical, professional and dignified, and does not interfere with traditional funeral and burial customs. There is no cost to the family of the donor for these procedures.

Advance directives regarding organ donation can be made in a will, through an organ donation card, or driver's license notation or by means of other written documents signed by the donor in the presence of two adult witnesses, who must also sign.

You may, at any time, change your mind about your decision by revoking or amending your will or other document or by writing "VOID" across the organ donation card.

Such a card is included in this brochure; in Nevada, you can also sign the reverse side of your driver's license to indicate your willingness to be an organ donor.

Because families are typically consulted before organ donation takes place, you should discuss your decision with your family and physician.

***If I am not for me,***
***who will be?***
***And if not now,***
***when?***

---

## Organ Donor Card

I, _____, hereby make the
following anatomical gift, if medically acceptable, to take effect to take effect upon my death.

☐ Any organs or part ☐ Entire body

Only the following specific organs or parts:

_____

Limitations or special wishes, if any:

_____

(Signature of donor and witness appear on reverse side.)

## Organ Donor Card (side two)

Signed by the donor and the following two witnesses in the presence of each other.

Donor Signature: _____

Date of Birth: _____

Date Signed: _____

City and State: _____

Witness Signature: _____

Witness Signature: _____

This is a legal document under the Uniform Anatomical Gift Act or similar laws.

---

## Power of Attorney for Health Care

*Notification Card*

I, _____, have signed a Power of Attorney for Health Care authorizing my named agent to make all my health care decisions for me if I am unable to do so.

Agent Name: _____

Day phone:_____ Eve. phone: _____

Successor agent name: _____

Day phone:_____ Eve. phone: _____

## Declaration/DPAHC

*Notification Card*

I, _____, have signed a Declaration DPAHC.

If my condition is terminal, a copy may be obtained from:

Name: _____

Day Phone:_____

Eve Phone:_____