DOWNLOAD COVERSHEET:

This is a standard advance directive for your state, made available to you as a courtesy by Lifecare Directives, LLC. You should be aware that extensive research has demonstrated that there are significant drawbacks to using a very brief state-standard document. As one researcher has noted, "the development of statutory forms occurs in the legislative arena, [so] their content is the result of a political rather than a 'scientific' process." Because of "political compromise, ...many of the forms ultimately passed by the legislatures are not optimal from a consumer perspective" (see: Hoffmann, Diane E; Zimmerman, S; Tompkins, C. The dangers of directives, or the false security of forms. *Journal of Law, Medicine & Ethics*. 19XX;24(1) (Spring):5-17).

American Bar Association concurs, noting that "The statutory advance directive is not necessarily the exclusive, or even the best, pathway for individuals to follow," and suggesting that revised and enhanced documents "may be especially helpful as a...replacement for statutory forms where restrictions in a statutory directive prevents the individual from fully expressing his or her wishes" (see: American Bar Association. (19XX). *Patient Self Determination Act State Law Guide*. Government printing office, Washington, DC).

Lifecare Directives staff have reviewed more than 6,000 medical, legal, academic, and news media articles on advance directives, as well as reviewing hundreds of document forms. They have also conducted formal research with scores of medical, legal, and academic processionals along with more than 1,000 lay public participants. From this process, more than 30 additional key living will and medical power of attorney enhancements have been identified that should be included in any living will (or "health care instruction" or "declaration") and medical power of attorney (or "proxy") forms that you may use.

Please consider obtaining the *Lifecare Advance Healthcare Directive* to obtain these important additions and benefits. To better understand the important enhancements available through this combined living will and medical power of attorney, you may wish to obtain the booklet, "*Should I Use a Shorter Standard Directive?*" available through Lifecare Directives, LLC.

If you have any other questions about this document or other Lifecare resources, please do not hesitate to contact our staff who will make every effort to fully respond your inquiries and address any questions you may have. We can be reached at the following:

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~ Lifecare Directives ~

Statutory Advance Directive

For Louisiana Residents

Standard State Statutory Advance Directive for Health Care Choices

~ Lifecare Directives ~

Statutory Advance Directive

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Standard State Statutory Advance Directive for Health Care Choices

Important Notice:

An advance directive is not a substitute for medical, legal or other necessary advice or direction. This document should not be construed as offering counseling, medical, legal, financial, or estate planning or advice, nor any other similar guidance or direction. Such counsel should be obtained from qualified, certified, and licensed professionals in your locale who are experienced in the specific areas of concern. Completion of this document constitutes acceptance of its content both in whole and in part, as well as a determination of its utility for the purposes indicated. Lifecare Directives, LLC, and all involved in this document's design, publication, and distribution assume no liability for its use, including that which may arise from omissions, technical inaccuracies, and typographical errors. Diligent efforts notwithstanding, this document is not warrantied to be in compliance with state and local laws. All warranties, including those of merchantability, fitness for a particular purpose, and non-infringement are expressly disclaimed. The utilizer agrees to seek appropriate outside review prior to completion. The utilizer and all heirs, assigns, designees, devisees, representatives, and all others involved, agree to assume all liability for its use and any subsequent outcomes, and to release and hold harmless all involved in its design, publication, advertising and distribution. The utilizer also agrees that any physician, health care provider, agent, proxy, surrogate, representative, mediator, court officer, and all others relying on the document's content are similarly free of all liability, when they act in good faith and with due diligence to follow the recorded wishes and directions.

Statutory Advance Directive For Louisiana Residents

_____ _____

Print Full Name *Date of Birth*

Your right *(when age 18 or older): To Document Your Personal Wishes, and to have these wishes followed ~~*

The Louisiana legislature has designed a living will thorough which to document your health care treatment choices. Other statutes govern Acts of Procuration, and Mandate, allowing for the nomination of a representative health care agent. Outside of Louisiana, this designation is more commonly known as a Power of Attorney for Health Care agent. Collectively, these documents are known "advance directives."

There is an introduction to each that summarizes the scope and purpose of the documents, as well as providing further directions for completion. Read it carefully to ensure that your advance directives are fully and properly filled out.

Understanding Your Directive

To make the *best* choices for your medical care, your physician needs to know *your* wishes. In fact, the law requires doctors to seek your permission before giving you *any* treatment. However, if you are ever unable to make decisions due to severe illness or injury, this may not be possible. Completing this Directive will help your family and physicians know who should speak for you, and understand what you want if you cannot make this known yourself.

You can **revoke** (cancel) this directive at ***any*** time by: **1**) writing "revoked" across the front of the directive, followed by your signature and date, and the signature of at least one witness aged 18 years or older ; or **2**) by completing a Notice of Revocation; or **3**) by *telling* an adult witness that you want it revoked (who must then sign and date a statement, which becomes effective only when given to your doctor or health care provider); or **4**) *by simply completing a new directive* in which you state that any prior directive is no longer valid (as is already stated in this directive).

You can **limit** your directive and the authority of anyone named in it, but *no changes are recommended after the document is witnessed*. Any scope-of-authority or content changes needed *after* your directive has been witnessed should be made by completing a new directive. First-time changes can be made by lining out anything in the directive and writing "deleted" beside that clause or section (or initialing above any word(s) you have lined out), followed by your signature, and the signature of at least one of the persons serving as a witness to this document, placed in the margin immediately beside the change.

If you are **unable to write**, you may tell your directive witnesses what you want to have excluded, limited, or added to this directive. They must then sign, date, witness and/or notarize

the statement of the limitations and exclusions as you have described them. Remember, unless you direct otherwise, this directive will **only** be used to guide your family and doctors if you are unable to make and communicate medical treatment decisions for yourself.

Instructions for Completing the Directive:

This directive is written in two parts. While it is best if you fill out the whole document, you may choose to complete only ***Section I***, leaving just a statement of your values and wishes. Or you may complete only ***Section II***, just naming someone to speak for you. However, this may leave your family and others without any evidence to support your wishes in the future, or leave them unsure who is to make decisions and speak for you. Thus, omitting either section may cause your loved ones difficulty if they must eventually make medical choices in your behalf. So, you are strongly encouraged to complete the entire directive.

To complete each document, you should ***initial*** in the underlined spaces provided beside all the questions that are asked, and fill in any blank lines as directed. Feel free to write "No," "None," or "Does Not Apply" in areas that would otherwise be left blank.

SECTION I:

LOUISIANA DECLARATION

and Personal Instructions

(RS Title 40: Part XXIV-A §1299.58.1 to §1299.58.10)

1. INTRODUCTION: *The declaration may, but need not, be in the following form and may include other specific directions including but not limited to a designation of another person to make the treatment decision for the declarant should he or she be diagnosed as having a terminal and irreversible condition and be comatose, incompetent, or otherwise mentally or physically incapable of communications*:

DECLARATION

Declaration made this _____ day of _____ 20_____.

I, _____, being of sound mind, do willfully and voluntarily make known my desire that my dying shall not be artificially prolonged under the circumstances set forth below and do hereby declare:

If at any time I should have an incurable injury, disease or illness, or be in a continual profound comatose state with **no** reasonable chance of recovery, certified to be a terminal and irreversible condition by two physicians who have personally examined me (one of whom shall be my attending physician), and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized — and where the application of life-sustaining procedure would serve only to prolong artificially the dying process, — then I hereby direct the following:

(*initial only <u>one</u>*)

_____ That ***<u>all</u>*** life-sustaining procedures, ***<u>including</u>*** nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.

_____ That life-sustaining procedures, ***<u>except</u>*** nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

I further direct that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care.

Other Specific Directions _____
_____
_____
_____
_____
_____
_____

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Should any of the other specific directions be held to be invalid, such invalidity shall not affect other directions of the declaration which can be given effect without the invalid direction, and to this end the directions in the declaration are severable.

I understand the full import of this declaration and I am emotionally and mentally competent to make this declaration.

Signed _____
Date _____
City, Parish, and State of Residence _____

Statement of Witnesses

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness: _____
Printed Name:_____
Address: _____

Witness: _____
Printed Name:_____
Address: _____

SECTION II:
POWER OF ATTORNEY FOR HEALTH CARE

(Designation of Health Care Agent by Act of Procuration and/or rules of Mandate)

(Louisiana Civil Code: Title XV, Articles §2985 to §3034, and/or §3890)

45. INTRODUCTION: *This section lets you name a person (called an "agent," or "representative," or "attorney-in-fact") to make health care decisions for you, if you cannot make them for yourself. The person you name must be at least 18 years of age. Unless you indicate otherwise, the powers which you may grant through this document include the authority to make health care decisions, including life-sustaining treatment decisions, as well as other authorities regarding related affairs. If you have questions, you should seek further counsel and advice*.

46. ***Be it known that I***:

Full Legal Name: _____

Date of Birth: _____

Street Address: _____

City: _____ County: _____

State: _____ Zip Code: _____

~~ Intend by this document to create a power of attorney for health care. This power of attorney shall not be affected by my later disability, incompetency, or incapacity (as the "principal" herein *(pursuant to LA CC Art.§3026)*). I am of sound mind, and state that the execution of this document is voluntary and without duress. Creation of this power of attorney is for the purpose of designating someone to act as my health care agent (also known as my attorney-in-fact), to act in my place to make medical decisions for me if I become unable to make them for myself . This designation is conditional *(§9:3890, unless stipulated otherwise elsewhere in this document)*, becoming effective when, in the opinion of at least one licensed medical doctor who has personally examined me, I am no longer able make personal medical treatment decisions for myself. By creating this document I revoke any prior power of attorney for health care.

47. I understand that I am <u>not</u> required to choose an agent, but that I am advised to do so to ensure that my wishes are fully represented and followed. Therefore:

(*initial only <u>one</u>*)

_____ I do **<u>not</u>** want to choose a health care agent at this time (*or I have no one appropriate to the task*). However, I instruct that Section I of this document be recognized (by statutory law, case law, common law and/or federal law) as a declaration of my wishes within this Advance Health Care Directive (*proceed now to sign on page 5*);

OR,

_____ I **<u>do</u>** want to appoint a health care agent. I recognize that this person should *<u>not</u>* be my health care provider nor an employer of my health care provider, unless related to me by blood, marriage or adoption. The person I have chosen to make, name,

constitute and appoint to act as my agent and to whom I give **full** authority to make all medical and health care decisions for me at any time during which I am unable to make them for myself, is:

Name of Agent: _____
A Resident of Parish: _____
Address: _____
Telephone: Home:_____ Work:_____
Cell Phone or Pager: _____ E-mail: _____

Specific Agent Authority and General Intent

My agent shall have the same authority to make health care decisions for me as I would if I had the capacity to make them myself. This shall include the authority to consent, refuse consent, renew or withdraw consent to any treatment, tests, medications, care, services, surgery or therapies used to diagnose or treat any physical or mental condition. This authorization includes the authority to consent to the provision, withholding or withdrawal of any life-sustaining treatment or procedure *even* if the consent or refusal of such will result in my death; **and** to legally act in *every* other matter related to my health and personal care with that same authority I would have, without incurring any personal, legal or financial liability for such. My intent is to facilitate the management of any and all medical matters necessary to provide for my health care and well-being by my agent in whom I have full faith and confidence, and to avoid costly conservatorship or other legal and court proceedings, where possible.

I understand the full import of this designation, and I am emotionally and mentally competent to make this appointment and grant these powers and authorities.

Signed _____
Date _____
City, Parish, and State of Residence _____

Statement of Witnesses

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness: _____
Printed Name:_____
Address: _____

Witness: _____
Printed Name:_____
Address: _____

CERTIFICATE OF ACKNOWLEDGMENT OF NOTARY PUBLIC (*optional*):
State of *Louisiana*,

Parish of_____ }

Place: _____

On this_____day of _____, in the year_____, before me (insert officer name/title): _____, personally appeared (insert name of Principal on line here):_____, personally known to me (or proved to me on the basis of satisfactory evidence (describe:_____)) to be the person(s)

whose name is subscribed to this/these instrument(s) and acknowledged to me that he/she executed the same in his/her authorized capacity, and that by his/her signature on the instrument(s), executed the instrument(s). I declare that he/she appears of sound mind and not under or subject to duress, fraud, or undue influence, that he/she acknowledges the execution of the same to be his/her voluntary act and deed, and that I am not the agent (attorney-in-fact), proxy, surrogate, or a successor of any such, as designated within this document, nor do I hold any interest in his/her estate through a Will or by other operation of law.

WITNESS my hand and official seal.

98. _____ **Notary Seal:**
Signature of Notary Public

_____
Date Commission Expires