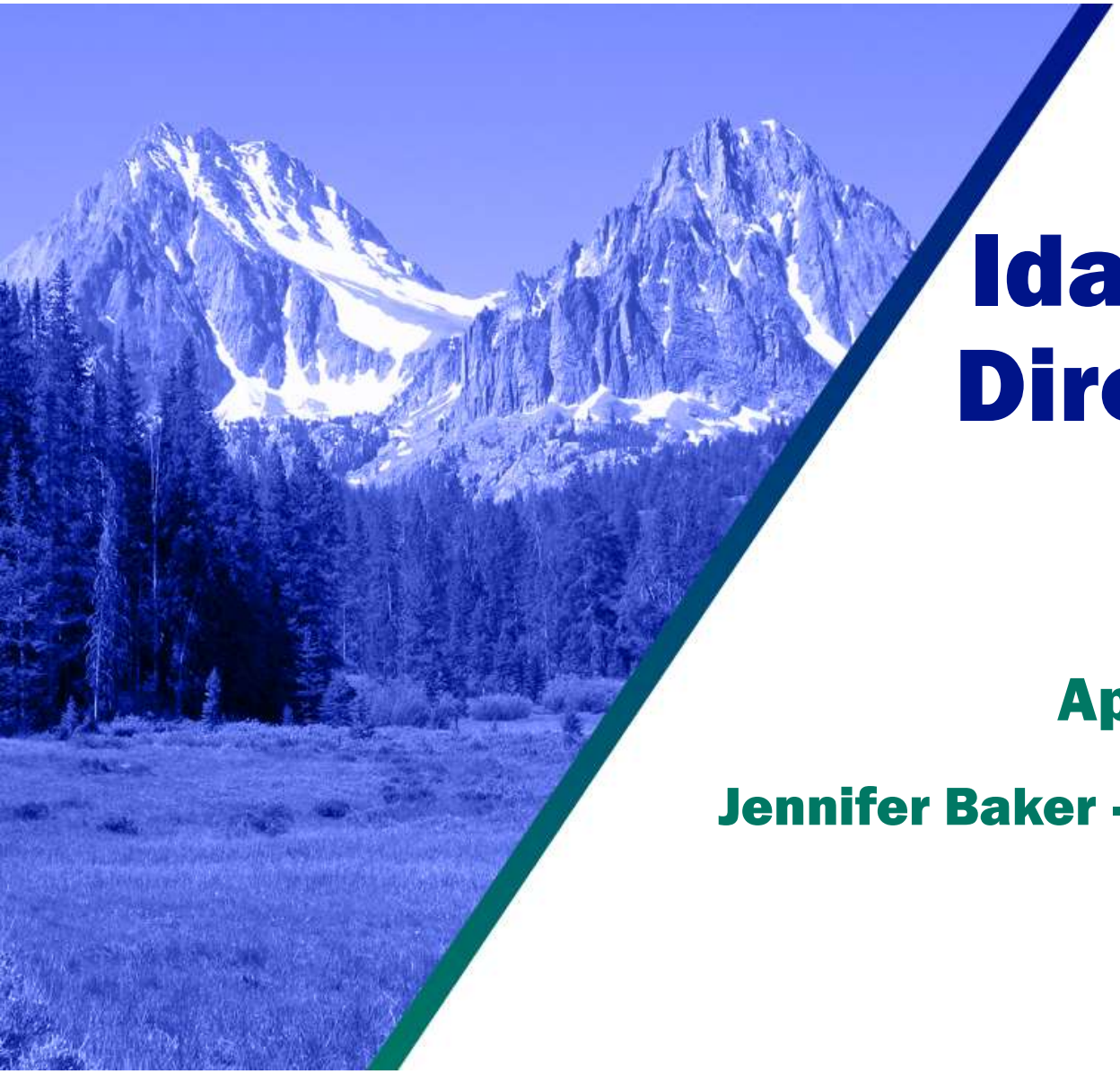


Idaho Healthcare Directive Registry

April 12, 2022

Jennifer Baker – Health Program Manager

IDAHO DEPARTMENT OF HEALTH & WELFARE

What Is It & How Did We Get Here?

IDAHO
HEALTHCARE
DIRECTIVE REGISTRY
Your voice. Your choice.

Healthcare Advance Directive

IDAHO DURABLE POWER OF ATTORNEY FOR HEALTHCARE AND LIVING WILL

Print Name: Jon Vynca **Date of Directive:** 10/22/2021

Address: 1245 Hospital Drive. Developer, ID 83705 **Birth Date:** 5/01/1975

An Advance Directive is a general term used to describe this document. There are two parts: 1) the Durable Power of Attorney for Healthcare and 2) the Living Will. The purpose of this form is to help you plan ahead so your loved ones and healthcare team know what care you want if you experience a medical crisis and cannot speak for yourself.

DURABLE POWER OF ATTORNEY FOR HEALTHCARE

This portion of my Advance Directive creates a durable power of attorney for healthcare. This power of attorney will remain in effect if I become incapacitated and shall be effective **only** when I am unable to communicate or make my own healthcare decisions.

For the purposes of this Advance Directive, "healthcare decision" means:

- Consent
- Refusal of consent; or
- Withdrawal of consent

to any care, treatment, or procedure to maintain, diagnose or treat an individual's medical condition.

1. **DESIGNATION OF AGENT**. I designate and appoint the following individual as my healthcare agent to make healthcare decisions for me as authorized in this Advance Directive:

Name of Healthcare Agent: Emily Waltham

Relationship: Sister Phone Number of Healthcare Agent: (208) 867-5309

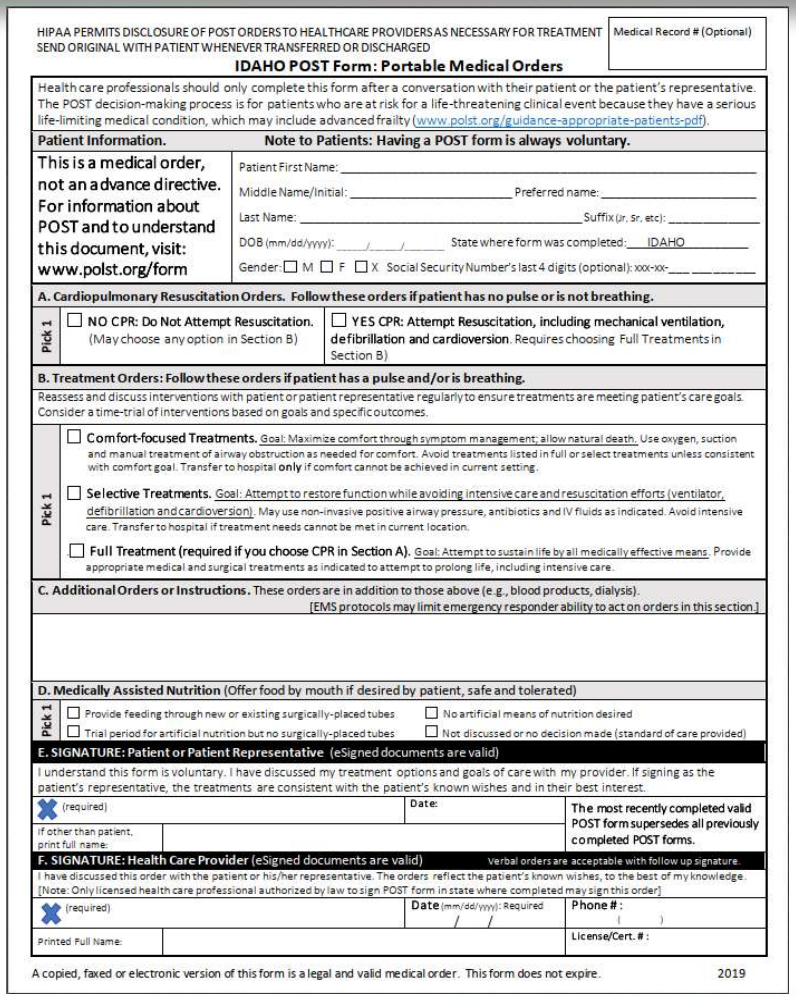
Address: 590 W. Science Center Place. Twin Falls, ID 83301

2. **DESIGNATION OF ALTERNATE AGENTS**. If the person designated as my healthcare 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 designation or authority to act as my agent to make healthcare decisions for me,

then I designate and appoint the following person to serve as my agent to make healthcare decisions for me as authorized in this Advance Directive (*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 person is unable or ineligible to act as your agent.)*

Physician Orders for Scope of Treatment



HIPAA PERMITS DISCLOSURE OF POST ORDERS TO HEALTHCARE PROVIDERS AS NECESSARY FOR TREATMENT
SEND ORIGINAL WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED

Medical Record # (Optional)

IDAHO POST Form: Portable Medical Orders

Health care professionals should only complete this form after a conversation with their patient or the patient's representative. The POST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty (www.polst.org/guidance-appropriate-patients-pdf).

Patient Information. **Note to Patients: Having a POST form is always voluntary.**

This is a medical order, not an advance directive. For information about POST and to understand this document, visit: www.polst.org/form

Patient First Name: _____

Middle Name/Initial: _____ Preferred name: _____

Last Name: _____ Suffix (Jr, Sr, etc): _____

DOB (mm/dd/yyyy): ____/____/____ State where form was completed: IDAHO

Gender: ☐ M ☐ F ☐ X Social Security Number's last 4 digits (optional): xxx-xx-____

A. Cardiopulmonary Resuscitation Orders. Follow these orders if patient has no pulse or is not breathing.

Pick 1

☐ **NO CPR: Do Not Attempt Resuscitation.** (May choose any option in Section B)

☐ **YES CPR: Attempt Resuscitation, including mechanical ventilation, defibrillation and cardioversion.** Requires choosing Full Treatments in Section B)

B. Treatment Orders: Follow these orders if patient has a pulse and/or is breathing.

Reassess and discuss interventions with patient or patient representative regularly to ensure treatments are meeting patient's care goals. Consider a time-trial of interventions based on goals and specific outcomes.

Pick 1

☐ **Comfort-focused Treatments.** Goal: Maximize comfort through symptom management; allow natural death. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Avoid treatments listed in full or select treatments unless consistent with comfort goal. Transfer to hospital **only** if comfort cannot be achieved in current setting.

☐ **Selective Treatments.** Goal: Attempt to restore function while avoiding intensive care and resuscitation efforts (ventilator, defibrillation and cardioversion). May use non-invasive positive airway pressure, antibiotics and IV fluids as indicated. Avoid intensive care. Transfer to hospital if treatment needs cannot be met in current location.

☐ **Full Treatment (required if you choose CPR in Section A).** Goal: Attempt to sustain life by all medically effective means. Provide appropriate medical and surgical treatments as indicated to attempt to prolong life, including intensive care.

C. Additional Orders or Instructions. These orders are in addition to those above (e.g., blood products, dialysis).
[EMS protocols may limit emergency responder ability to act on orders in this section.]

D. Medically Assisted Nutrition (Offer food by mouth if desired by patient, safe and tolerated)

Pick 1

☐ Provide feeding through new or existing surgically-placed tubes
☐ Trial period for artificial nutrition but no surgically-placed tubes
☐ No artificial means of nutrition desired
☐ Not discussed or no decision made (standard of care provided)

E. SIGNATURE: Patient or Patient Representative (eSigned documents are valid)

I understand this form is voluntary. I have discussed my treatment options and goals of care with my provider. If signing as the patient's representative, the treatments are consistent with the patient's known wishes and in their best interest.

✖ (required) Date:

If other than patient, print full name:

The most recently completed valid POST form supersedes all previously completed POST forms.

F. SIGNATURE: Health Care Provider (eSigned documents are valid) Verbal orders are acceptable with follow up signature.

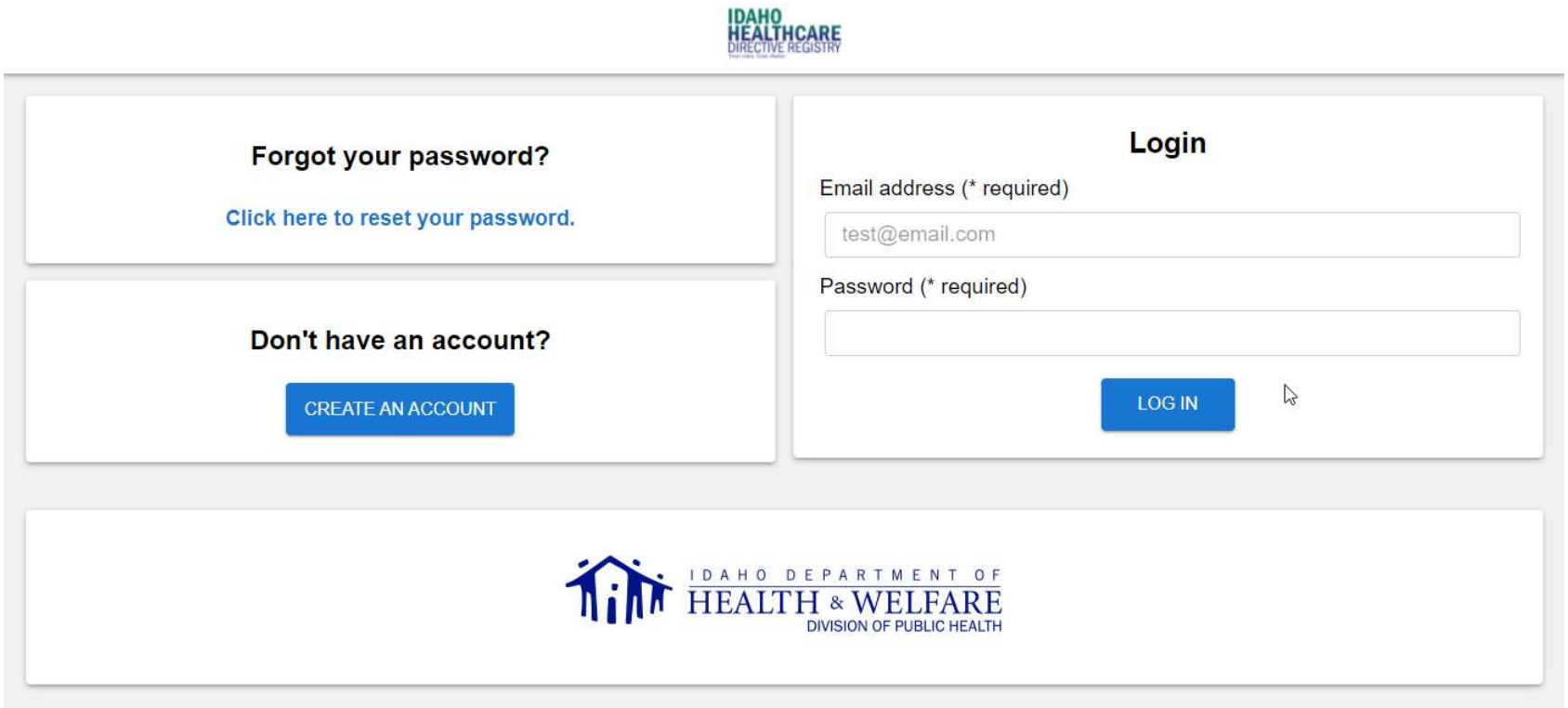
I have discussed this order with the patient or his/her representative. The orders reflect the patient's known wishes, to the best of my knowledge. [Note: Only licensed health care professional authorized by law to sign POST form in state where completed may sign this order]

✖ (required) Date (mm/dd/yyyy): Required ___/___/___ Phone #: (___)

Printed Full Name: License/Cert. #:

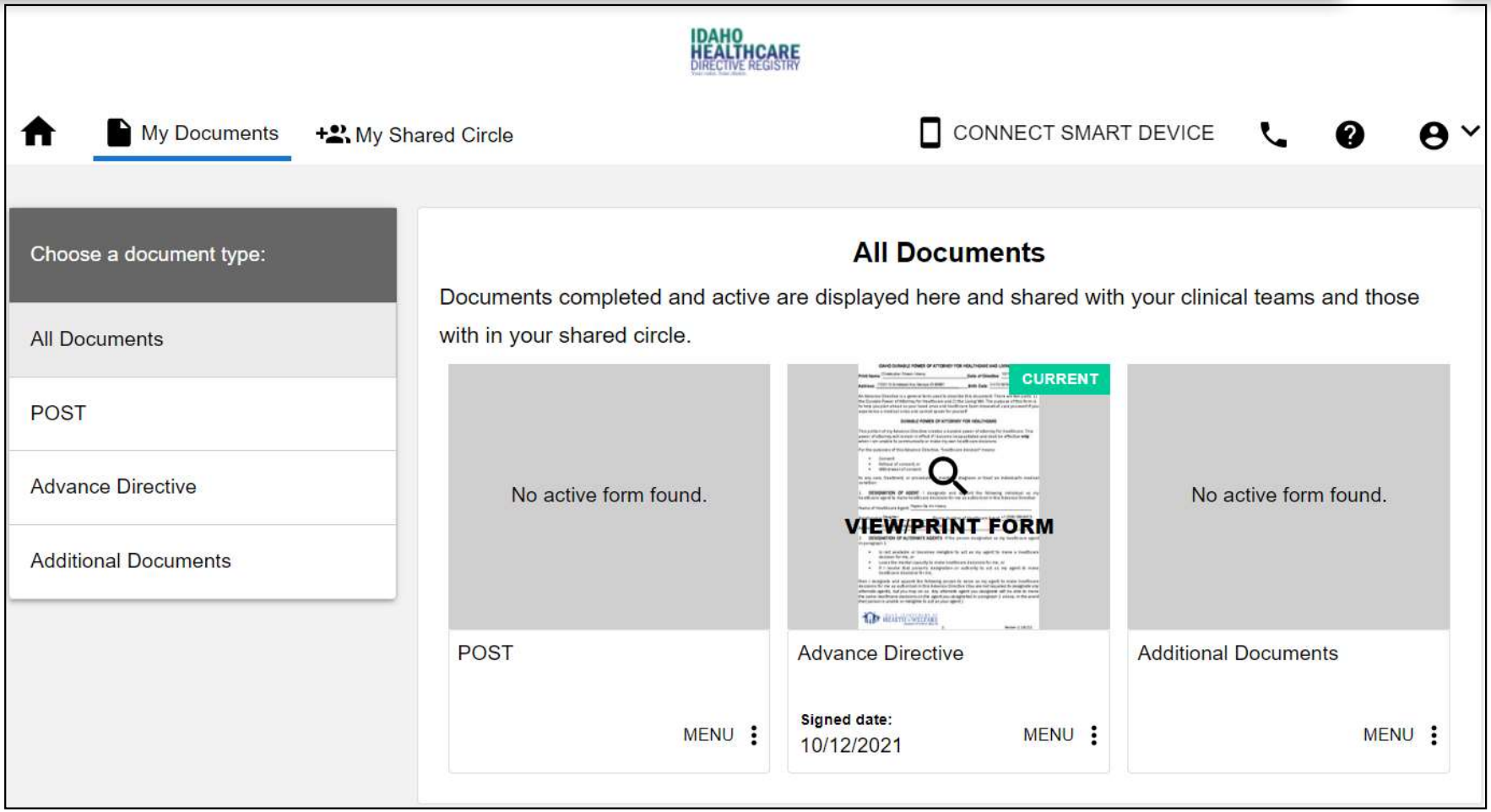
A copied, faxed or electronic version of this form is a legal and valid medical order. This form does not expire. 2019

Vynca Health – Patient Portal



https://idaho-acp.vyncahealth.com

Patient Registry Account



Additional Resources

https://healthandwelfare.idaho.gov/services-programs/birth-marriage-death-records/advance-directives-and-registry-services

We're Excited About OUR New Registry!

IDAHO HEALTHCARE DIRECTIVE REGISTRY

Your voice. Your choice.

IHDR@dhw.Idaho.gov

208-334-5501

Idaho-acp.vyncahealth.com