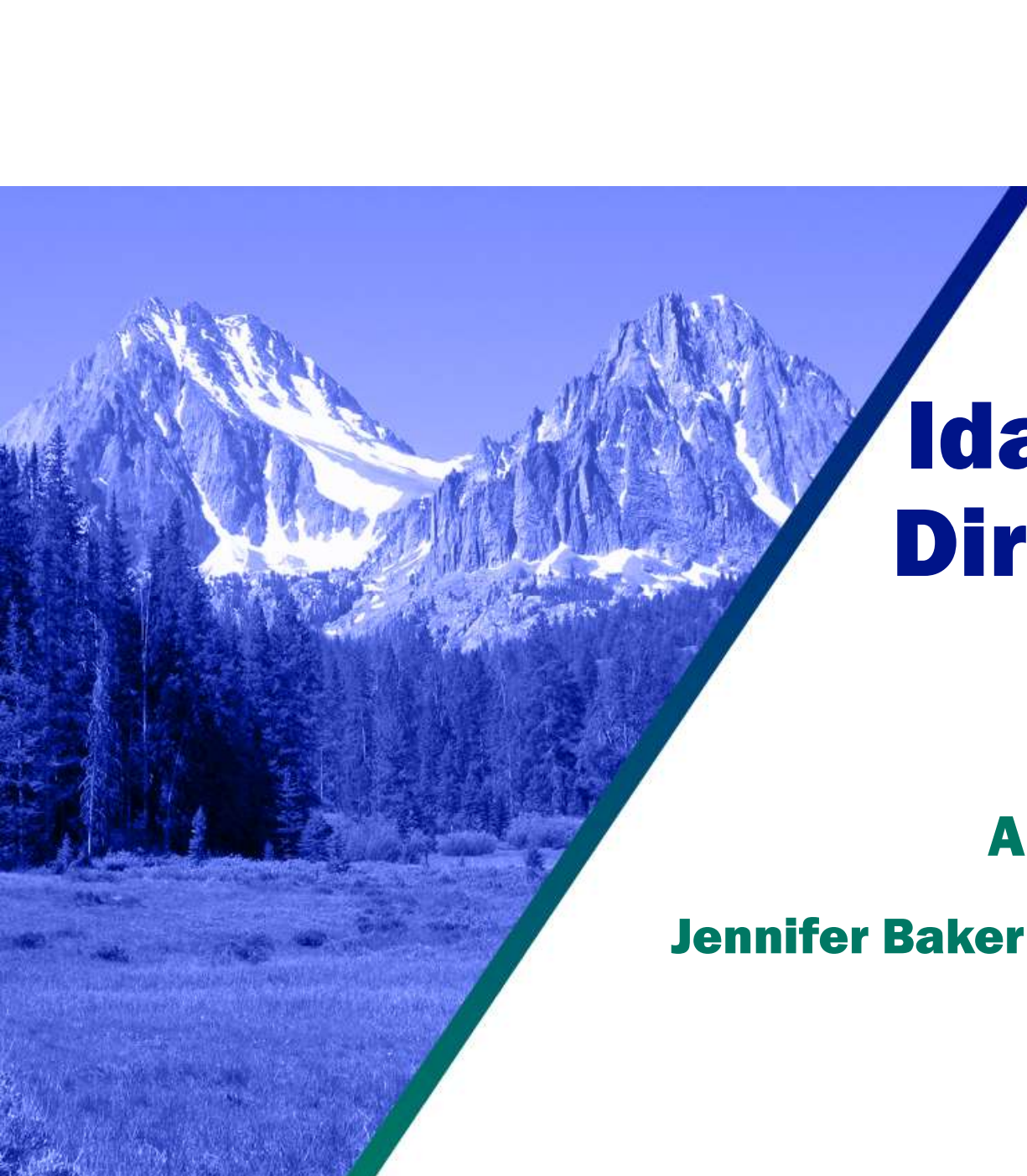




Idaho Healthcare Directive Registry

April 12, 2022

Jennifer Baker – Health Program Manager





IDAHO HEALTHCARE DIRECTIVE REGISTRY

Your voice. Your choice.

Healthcare Advance Directive

3



IDAHO DURABLE POWER OF ATTORNEY FOR HEALTHCARE AND LIVING WILL	
Print Name: <u>Jon Vynca</u>	Date of Directive: <u>10/22/2021</u>
Address: <u>1245 Hospital Drive, Developer, ID 83705</u> Birth Date: <u>5/01/1975</u>	
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: <u>Emily Waltham</u>	
Relationship: <u>Sister</u> Phone Number of Healthcare Agent: <u>(208) 867-5309</u>	
Address: <u>590 W. Science Center Place, Twin Falls, ID 83301</u>	
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 (<i>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.</i>)	
 IDAHO DEPARTMENT OF HEALTH & WELFARE DIVISION OF PUBLIC HEALTH	
1 Version 1.1 8/21	

Physician Orders for Scope of Treatment

4



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: <u>IDAHO</u>	
	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 <u>only</u> 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 ☐ No artificial means of nutrition desired	
	☐ Trial period for artificial nutrition but no surgically-placed tubes ☐ 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: _____	The most recently completed valid POST form supersedes all previously completed POST forms.
If other than patient, print full name: _____		
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		



Forgot your password?

[Click here to reset your password.](#)

Don't have an account?

[CREATE AN ACCOUNT](#)

Login

Email address (* required)

test@email.com

Password (* required)

[LOG IN](#)



IDAHO DEPARTMENT OF
HEALTH & WELFARE
DIVISION OF PUBLIC HEALTH

<https://idaho-acp.vyncahealth.com>

Patient Registry Account

6



My Documents My Shared Circle CONNECT SMART DEVICE

Choose a document type:

All Documents

POST

Advance Directive

Additional Documents

All Documents

Documents completed and active are displayed here and shared with your clinical teams and those with in your shared circle.

No active form found.

POST

MENU

DAVID DONALD POWER OF ATTORNEY FOR HEALTHCARE AND LONG-TERM CARE

Print Name: David Donal Power Date of Signature: 10/12/2021

APPROVE: 10/12/2021 By: David Donal Power Date of Signature: 10/12/2021

As someone I consider to be a person of sound mind and legal capacity, I hereby declare that I am the David Donal Power of Attorney for Healthcare and Long-Term Care. The purpose of this document is to give my loved ones and healthcare team the authority to make decisions on my behalf in the event I become unable to make decisions for myself.

APPROVE: 10/12/2021 By: David Donal Power Date of Signature: 10/12/2021

This document is a legal document that creates a binding contract between me and the healthcare providers. The purpose of this document is to give my loved ones and healthcare team the authority to make decisions on my behalf in the event I become unable to make decisions for myself.

VIEW/PRINT FORM

10/12/2021

Advance Directive

Signed date: 10/12/2021

MENU

No active form found.

Additional Documents

MENU

Additional Resources

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The screenshot shows the Idaho Department of Health & Welfare website. The header includes the department logo, navigation links for 'Services & Programs', 'Health & Wellness', and 'News & Notices', and a search icon. A breadcrumb trail reads: 'Home | Service & Programs | Birth, Marriage, & Death Records | Advance Directives and Registry Services'. The main heading is 'Advance Care Planning' with the tagline 'Your Voice. Your Choice.' Below this, a sidebar titled 'Explore this Section' lists 'Advance Directives and Registry Services' (highlighted), 'Start Your Advance Directive', and 'Idaho Healthcare Directive Registry'. The main content area features the title 'Advance Directives and Registry Services' followed by a paragraph explaining advance care planning. Below this is a section titled 'About Healthcare Advance Directives' with a paragraph explaining the purpose of an advance directive. To the right of this section is a box with the text 'Create or Upload Advance Directive Online' and a blue button labeled 'Visit Healthcare Directive Registry' with an external link icon.

IDAHO DEPARTMENT OF HEALTH & WELFARE

Services & Programs Health & Wellness News & Notices

Home | Service & Programs | Birth, Marriage, & Death Records | Advance Directives and Registry Services

Advance Care Planning

Your Voice. Your Choice.

Advance Directives and Registry Services

Advance care planning is the process of thinking and talking about future medical decisions and the kind of care you would want if you were too sick to speak for yourself. The best time to make these decisions is when you can choose for yourself and one of the best ways to be sure your wishes are honored is to create an Advance Directive.

About Healthcare Advance Directives

Thinking about being at the end of life or in a situation where you cannot speak for yourself is difficult and uncomfortable. Taking time to think through your choices in advance, talking about them with people close to you, and writing down your wishes will help you and your loved ones feel more prepared. An Advance Directive is a written plan that helps your loved ones and healthcare providers make important decisions about your care. It speaks for you when you are unable to speak for

Create or Upload Advance Directive Online

Visit Healthcare Directive Registry

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

We're Excited About OUR New Registry!

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IDAHO HEALTHCARE DIRECTIVE REGISTRY

Your voice. Your choice.



 IHDR@dhw.idaho.gov

 208-334-5501

 Idaho-acp.vyncahealth.com

