Ohio Legal Rights Service's
Durable Power of Attorney for Health Care Form

This form helps you to direct your care should your doctor decide that you lack capacity to make your own medical decisions. It is not intended as a substitute for legal advice, and you should contact a lawyer if you have questions about this document or what it does.

Introduction

There are two types of advance directives for mental health treatment. One type is the Declaration for Mental Health Treatment under Revised Code chapter 2135. The second type is the Durable Power of Attorney for Health Care under Revised Code chapter 1337. The following form is an advance directive under Revised Code chapter 1337, a Durable Power of Attorney for Health Care form.

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Instructions for filling out this form

In this document you name one or more people as your "agent" or "attorney-in-fact". You authorize your agent to make all physical and mental health care decisions for you, but only if your attending physician determines that you have lost the capacity to make informed health care decisions for yourself. You should review each section of this form. You must fill in your name and county of residence; the section appointing an agent; and the signature and date. You must sign the form in the presence of the witnesses and/or notary public. The declarations should be filled out only if you want to provide specific instructions to your agent about your treatment.

I. Appointment of Agent

I, _____, am an adult of sound mind who currently resides in _____ County, Ohio. After careful consideration, I knowingly and voluntarily make this durable power of attorney for health care and declaration of treatment preferences. I understand that this is a legally binding document.

I understand that this document will take effect only if my attending physician determines that my ability to receive and evaluate information is impaired to such an extent that I have lost the capacity to make informed health care decisions for myself. My agent can then begin making all physical and mental health care decisions for me. My agent will continue making all health care decisions for me until my attending physician determines that I have regained the capacity to make those decisions for myself.

Designation of my agent

I appoint the following person(s) to act as my agent to make health care decisions for me if my attending physician determines that I have lost the capacity to make informed health care decisions for myself. My agent has authority to make all physical and mental health care decisions for me, including the right to give, to refuse to give, or to withdraw informed consent to any health care treatment, as allowed by law.

I instruct my agent to make health care decisions for me consistent with my wishes as expressed in this document or, if not expressed here, as otherwise made known to my agent by me. If my agent does not know and is not able to determine what I want, I instruct my agent to act in what my agent believes to be my best interest.

I intend each of the individuals named below to succeed to the authority of and serve under this appointment, in the order named, if at any time the prior agent is not readily available or is unwilling to serve or to continue to serve, or is removed by me.

First choice:

I appoint _____, address _____,

daytime phone _____, evening phone _____,

as my agent to make all health care decisions for me.

Second choice:

I appoint _____, address _____,

daytime phone _____, evening phone _____,

Third choice:

I appoint _____, address _____,

daytime phone _____, evening phone _____,

My ability to revoke this document

I understand that I can revoke this document at any time and in any manner merely by expressing my intention to revoke it. This can be done verbally or in writing. If I have given a copy of this document to a physician, my revocation will not be effective as to that physician until the fact of my revocation is communicated to that physician (or the physician's staff) by me or by a witness to the revocation. I understand that if I execute a new durable power of attorney for health care, the new document will automatically replace this one.

Expiration date

(Initial one)

____ This durable power of attorney for health care has no expiration date, and shall not be affected by my disability or by the passage of time.

____ This durable power of attorney for health care shall expire at Midnight on the ____ day of _____ 20____, but otherwise is not affected by my disability or by the passage of time.

Severability

If a court finds any provision of this document to be invalid or unenforceable, that provision shall be severed from this document without affecting any other power or provision of this document, or the appointment of my agent to make health care decisions for me.

II. Declaration of Treatment Instructions

You may provide your agent with specific instructions about the choices you want made for you should this POA take effect. If you do not instruct your agent, either in this document or otherwise, the agent will still make choices about your health care and will decide based on your best interests. If you wish to provide instructions about your care to your agent, then fill out those sections of the form below that provide the direction you want to give. If you do not wish to provide instructions to your agent, then go to the signature section at page 11 at the end of this document.

Attending physician

I name the following doctor as my "attending physician". Under the law, this is the only physician who can make the determination as to whether I have lost the capacity to make informed health care decisions for myself for the purpose of this document.

Name: _____ Phone: _____

Address: _____

Other physicians I choose to provide treatment to me

In addition to the attending physician named above, I prefer to be treated by the following doctors, and I instruct my agent to request medical services for me from the following doctors:

Name: _____ Phone: _____

Address: _____

Specialty (if any): _____

Name: _____ Phone: _____

Address: _____

Specialty (if any): _____

I do <u>not</u> want to be treated by the following doctors, psychiatrists, or other mental health professionals, and I instruct my agent not to consent to my treatment by these individuals:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Medical conditions

I may have the following medical condition(s), which may cause or contribute to, or may appear similar to, psychiatric symptoms. I instruct that my agent have these medical conditions ruled out prior to authorizing psychiatric care or treatment. These medical conditions are:

_____ .

Medication

If my physician proposes that I be given medication, I instruct my agent to (choose one and initial):

____ consent to the medication proposed by my physician

____ consent to medication, except for _____, which I do not take because

(you may wish to explain why you do not wish to take this medication) _____ .

____ not consent to any medications

____ (other) _____ .

Allergies, other physical conditions, health problems, or medications that I want my agent to know about and consider before giving informed consent to medication: _____ .

I understand that, if I have instructed my agent not to consent to medication, and if I am involuntarily committed by a court order, it is possible that someone may file an application for forced medication with the probate court and request a court hearing on the question of whether I need to be medicated by court order. If there is a court hearing on the question of whether I am in need of medication, I instruct my agent to inform the court of my instructions as expressed in this document. However, I understand that the court is not required to follow my wishes as expressed in this document.

Electroconvulsive therapy

Note that ECT is not available in any hospitals operated by the Ohio Department of Mental Health.

If my physician proposes that I be given electro-convulsive therapy (ECT), I instruct my agent to (choose one and initial):

____ not consent to ECT under any circumstances

____ consent to ECT only after all other treatment options have been tried without success

____ consent to ECT

____ (other) _____ .

Restraint or seclusion

If it becomes necessary in the opinion of the hospital that I be placed in seclusion or restrained, either physically or chemically, I instruct my agent to (choose one and initial):

____ notwithstanding any other instructions about medication in this document, consent to medication rather than allow me to be placed in physical restraint

____ direct that I be secluded rather than medicated or restrained physically

____ consent only to such seclusion or restraint as are necessary to prevent me from harming myself or others, and this consent should be withdrawn at the point where I am no longer at such risk

____ (other) _____ .

Hospitalization

If it is determined that I need to be hospitalized, I instruct my agent as follows.

In a general medical hospital

If my physician determines that I need care or treatment in a general medical hospital, I instruct my agent to consent to my admission to the following general medical hospital(s):

First Choice: _____ Second Choice: _____

I instruct my agent not to consent to my admission to the following general medical hospital(s):

_____ .

In a psychiatric hospital (or licensed unit)

If my physician determines that I need care or treatment in a psychiatric hospital, I instruct my agent to consent to my admission to the following psychiatric hospital(s):

First Choice: _____ Second Choice: _____

I instruct my agent not to consent to my admission to the following psychiatric hospital(s):

_____ .

I understand that, by instructing my agent not to consent to my voluntary admission to the psychiatric hospital(s) named above, it is possible that someone may file with the probate court an affidavit of mental illness and request a court hearing on the question of whether I need to be admitted to a psychiatric hospital by court order, and if so, to which hospital. If there is a court hearing, I understand that the court is not required to follow my wishes as expressed in this document. If there is a court hearing on the question of whether I am in need of psychiatric hospitalization, I instruct my agent to inform the court of my instructions as expressed in this document.

Other directions to my agent

I instruct my agent to consider the following treatment preferences:

_____ .

I do not want the following treatments, and I instruct my agent not to consent to them:

_____ .

(Optional) The reason that I do not want these treatments is:

_____ .

(initial) ____ I wish to be treated by spiritual means through prayer alone, in accordance with a recognized religious method of healing. The recognized religious method of healing is: _____ .
I instruct my agent as follows concerning other medical or psychiatric care and treatment, or related issues:

_____ .

Withdrawal of nutrition and hydration when in a permanently unconscious state (required by law to be in capital letters).

[ ] ____ IF I HAVE MARKED THE FOREGOING BOX AND HAVE PLACED MY INITIALS ON THE LINE ADJACENT TO IT, MY AGENT MAY REFUSE, OR IN THE EVENT TREATMENT HAS ALREADY COMMENCED, WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY SUPPLIED NUTRITION AND HYDRATION IF I AM IN A PERMANENTLY UNCONSCIOUS STATE AND IF MY ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED ME DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT SUCH NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO ME OR ALLEVIATE MY PAIN.

Notification

If I am hospitalized, I request that my agent notify the following people of the fact of my hospitalization, and the hospital's name, address and telephone number (for example, family members, friends and employer):

Name: _____, address _____,

daytime phone _____, evening phone _____,

Name: _____, address _____,

daytime phone _____, evening phone _____,

I instruct my agent <u>not</u> to contact the following people:

_____, _____, _____ .

Nomination of Guardian

If I need a guardian, I would like the following person to become my guardian, and I make this nomination pursuant to Revised Code Sec. 1337.09 and 2111.02. If there is a guardianship hearing, I instruct my agent to notify the court of my wishes, but I understand that the court is not required to follow my wishes.

Name: _____, address _____,

daytime phone _____, evening phone _____ .

III. Principal's Acknowledgement and Signature

If I have signed an earlier durable power of attorney for health care, it will be automatically revoked by this document. If I have signed a declaration under Revised Code Chapter 2133 (commonly called a "Living Will"), it will not be revoked by this document.

I understand that if I should execute a Declaration for Mental Health Treatment under Revised Code chapter 2135, that the Declaration for Mental Health Treatment will revoke any provisions for mental health treatment previously stated in a Durable Power of Attorney for Health Care. Any provisions previously stated in the Durable Power of Attorney for Health Care specifically for physical or medical (non-mental health) care will remain in effect.

I understand that I should give copies of this document to the agent and alternate agents I have named in this document. I may also give a copy to my physician, psychiatrist, or other health care provider. However, I understand that if I give a copy of this document to my physician or psychiatrist and later revoke this document, my revocation does not become effective as to the physician or psychiatrist until I or a witness to the revocation notifies him/her (or his/her staff) that I have revoked this document. I understand that both my revocation and notice of revocation to my physician or psychiatrist can be done either verbally or in writing. However, it may be easier to prove I revoked it if I do so in writing.

I can make changes to this document before I sign it, and I agree to write my initials beside those changes. I understand that I cannot make changes to this document after I have signed it. Instead I must execute a new document.

Ohio law requires that I be given the notice printed at the end of this document. I have read this notice before signing this document.

I understand that this document will not be valid unless I sign it in the presence of either a notary public or two witnesses who meet the law's requirements.

THIS DURABLE POWER OF ATTORNEY WILL NOT BE VALID UNLESS IT IS EITHER (1) SIGNED BY TWO QUALIFIED WITNESSES WHO ARE PRESENT WHEN YOU SIGN OR ACKNOWLEDGE YOUR SIGNATURE OR (2) ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

I understand the terms and purpose of this document, and I sign my name after carefully considering this matter on this ____ day of _____ 200____, at _____County, Ohio.

_____ _____

Signature of Principal Principal's typed or printed name

Witnesses

I attest 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 not subject to duress, fraud, or undue influence. I also attest that I am not an agent named in this document, I am not the attending physician of the principal, I am not the administrator of a nursing home in which the principal is receiving care, and that I am an adult who is not related to the principal by blood, marriage or adoption.

Signature: _____ Date: _____

Print name: _____ Residence Address: _____

Signature: _____ Date: _____

Print name: _____ Residence Address: _____

Notary Ackknowledgement

State of Ohio

County of _____ss:

On this the _____day of _____, 200__,

_____, who is known to me or who has provided me with satisfactory proof of identity as the person whose name is subscribed above as the principal, personally appeared before me and acknowledged that s/he executed this document for the purposes described in the document. I attest that the principal appears to be of sound mind and not under or subject to duress, fraud or undue influence.

My Commission Expires:_____

_____
Notary Public

IV. Statutory Notice

Ohio law requires Ohio Revised Code section 1337.17 (Use of printed form; notice to principle) to be included in all Durable Power of Attorney for Health Care forms. The text of that statute follows:

1337.17. Use of printed form; notice to principal.

A printed form of durable power of attorney for health care may be sold or otherwise distributed in this state for use by adults who are not advised by an attorney. By use of such a printed form, a principal may authorize an attorney in fact to make health care decisions on the principal's behalf, but the printed form shall not be used as an instrument for granting authority for any other decisions. Any printed form that is sold or otherwise distributed in this state for the purpose described in this section shall include the following notice:

Notice to Adult Executing This Document (R.C. Sec.1337.17)

This is an important legal document. Before executing this document, you should know these facts:

This document gives the person you designate (the attorney in fact) the power to make MOST health care decisions for you if you lose the capacity to make informed health care decisions for yourself. This power is effective only when your attending physician determines that you have lost the capacity to make informed health care decisions for yourself and, notwithstanding this document, as long as you have the capacity to make informed health care decisions for yourself, you retain the right to make all medical and other health care decisions for yourself.

You may include specific limitations in this document on the authority of the attorney in fact to make health care decisions for you.

Subject to any specific limitations you include in this document, if your attending physician determines that you have lost the capacity to make an informed decision on a health care matter, the attorney in fact GENERALLY will be authorized by this document to make health care decisions for you to the same extent as you could make those decisions yourself, if you had the capacity to do so. The authority of the attorney in fact to make health care decisions for you GENERALLY will include the authority to give informed consent, to refuse to give informed consent, or to withdraw informed consent to any care, treatment, service, or procedure to maintain, diagnose, or treat a physical or mental condition.

HOWEVER, even if the attorney in fact has general authority to make health care decisions for you under this document, the attorney in fact NEVER will be authorized to do any of the following:

(1) Refuse or withdraw informed consent to life-sustaining treatment (unless your attending physician and one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that either of the following applies:

(a) You are suffering from an irreversible, incurable, and untreatable condition caused by disease, illness, or injury from which (i) there can be no recovery and (ii) your death is likely to occur within a relatively short time if life-sustaining treatment is not administered, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself.

(b) You are in a state of permanent unconsciousness that is characterized by you being irreversibly unaware of yourself and your environment and by a total loss of cerebral cortical functioning, resulting in you having no capacity to experience pain or suffering, and your attending physician additionally determines, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that there is no reasonable possibility that you will regain the capacity to make informed health care decisions for yourself);

(2) Refuse or withdraw informed consent to health care necessary to provide you with comfort care (except that, if he is not prohibited from doing so under (4) below, the attorney in fact could refuse or withdraw informed consent to the provision of nutrition or hydration to you as described under (4) below). (YOU SHOULD UNDERSTAND THAT COMFORT CARE IS DEFINED IN OHIO LAW TO MEAN ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) WHEN ADMINISTERED TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH, AND ANY OTHER MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE THAT WOULD BE TAKEN TO DIMINISH YOUR PAIN OR DISCOMFORT, NOT TO POSTPONE YOUR DEATH. CONSEQUENTLY, IF YOUR ATTENDING PHYSICIAN WERE TO DETERMINE THAT A PREVIOUSLY DESCRIBED MEDICAL OR NURSING PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN, THEN, SUBJECT TO (4) BELOW, YOUR ATTORNEY IN FACT WOULD BE AUTHORIZED TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROCEDURE, TREATMENT, INTERVENTION, OR OTHER MEASURE.);
(3) Refuse or withdraw informed consent to health care for you if you are pregnant and if the refusal or withdrawal would terminate the pregnancy (unless the pregnancy or health care would pose a substantial risk to your life, or unless your attending physician and at least one other physician who examines you determine, to a reasonable degree of medical certainty and in accordance with reasonable medical standards, that the fetus would not be born alive);

(4) REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF ARTIFICIALLY OR TECHNOLOGICALLY ADMINISTERED SUSTENANCE (NUTRITION) OR FLUIDS (HYDRATION) TO YOU, UNLESS:

(A) YOU ARE IN A TERMINAL CONDITION OR IN A PERMANENTLY UNCONSCIOUS STATE.

(B) YOUR ATTENDING PHYSICIAN AND AT LEAST ONE OTHER PHYSICIAN WHO HAS EXAMINED YOU DETERMINE, TO A REASONABLE DEGREE OF MEDICAL CERTAINTY AND IN ACCORDANCE WITH REASONABLE MEDICAL STANDARDS, THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN.

(C) IF, BUT ONLY IF, YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE, YOU AUTHORIZE THE ATTORNEY IN FACT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU BY DOING BOTH OF THE FOLLOWING IN THIS DOCUMENT:

(I) INCLUDING A STATEMENT IN CAPITAL LETTERS OR OTHER CONSPICUOUS TYPE, INCLUDING, BUT NOT LIMITED TO, A DIFFERENT FONT, BIGGER TYPE, OR BOLDFACE TYPE, THAT THE ATTORNEY IN FACT MAY REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU IF YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE AND IF THE DETERMINATION THAT NUTRITION OR HYDRATION WILL NOT OR NO LONGER WILL SERVE TO PROVIDE COMFORT TO YOU OR ALLEVIATE YOUR PAIN IS MADE, OR CHECKING OR OTHERWISE MARKING A BOX OR LINE (IF ANY) THAT IS ADJACENT TO A SIMILAR STATEMENT ON THIS DOCUMENT;

(II) PLACING YOUR INITIALS OR SIGNATURE UNDERNEATH OR ADJACENT TO THE STATEMENT, CHECK, OR OTHER MARK PREVIOUSLY DESCRIBED.

(D) YOUR ATTENDING PHYSICIAN DETERMINES, IN GOOD FAITH, THAT YOU AUTHORIZED THE ATTORNEY IN FACT TO REFUSE OR WITHDRAW INFORMED CONSENT TO THE PROVISION OF NUTRITION OR HYDRATION TO YOU IF YOU ARE IN A PERMANENTLY UNCONSCIOUS STATE BY COMPLYING WITH THE REQUIREMENTS OF (4)(C)(I) AND (II) ABOVE.

(5) Withdraw informed consent to any health care to which you previously consented, unless a change in your physical condition has significantly decreased the benefit of that health care to you, or unless the health care is not, or is no longer, significantly effective in achieving the purposes for which you consented to its use.

Additionally, when exercising his authority to make health care decisions for you, the attorney in fact will have to act consistently with your desires or, if your desires are unknown, to act in your best interest. You may express your desires to the attorney in fact by including them in this document or by making them known to him in another manner.

When acting pursuant to this document, the attorney in fact GENERALLY will have the same rights that you have to receive information about proposed health care, to review health care records, and to consent to the disclosure of health care records. You can limit that right in this document if you so choose.

Generally, you may designate any competent adult as the attorney in fact under this document. However, you CANNOT designate your attending physician or the administrator of any nursing home in which you are receiving care as the attorney in fact under this document. Additionally, you CANNOT designate an employee or agent of your attending physician, or an employee or agent of a health care facility at which you are being treated, as the attorney in fact under this document, unless either type of employee or agent is a competent adult and related to you by blood, marriage, or adoption, or unless either type of employee or agent is a competent adult and you and the employee or agent are members of the same religious order.
This document has no expiration date under Ohio law, but you may choose to specify a date upon which your durable power of attorney for health care generally will expire. However, if you specify an expiration date and then lack the capacity to make informed health care decisions for yourself on that date, the document and the power it grants to your attorney in fact will continue in effect until you regain the capacity to make informed health care decisions for yourself.

You have the right to revoke the designation of the attorney in fact and the right to revoke this entire document at any time and in any manner. Any such revocation generally will be effective when you express your intention to make the revocation. However, if you made your attending physician aware of this document, any such revocation will be effective only when you communicate it to your attending physician, or when a witness to the revocation or other health care personnel to whom the revocation is communicated by such a witness communicate it to your attending physician.

If you execute this document and create a valid durable power of attorney for health care with it, it will revoke any prior, valid durable power of attorney for health care that you created, unless you indicate otherwise in this document.

This document is not valid as a durable power of attorney for health care unless it is acknowledged before a notary public or is signed by at least two adult witnesses who are present when you sign or acknowledge your signature. No person who is related to you by blood, marriage, or adoption may be a witness. The attorney in fact, your attending physician, and the administrator of any nursing home in which you are receiving care also are ineligible to be witnesses.

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