COLORADO
Advance Directive
Planning for Important Healthcare Decisions

Courtesy of CaringInfo
www.caringinfo.org
800-658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care and the experience of caregiving during serious illness and at the end of life. As part of that effort, CaringInfo provides detailed guidance for completing advance directive forms in all 50 states, the District of Columbia, and Puerto Rico.

This package includes:

- Instructions for preparing your advance directive. Please read all the instructions.
- Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

BEFORE YOU BEGIN

Check to be sure that you have the materials for each state in which you may receive healthcare. Because documents are state-specific, having a state-specific document for each state where you may spend significant time can be beneficial. A new advance directive is not necessary for ordinary travel into other states. The advance directives in this package will be legally binding only if the person completing them is a competent adult who is 18 years of age or older, or an emancipated minor.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy, scan, or take a photo of the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, healthcare providers, and/or faith leaders so that the form is available in the event of an emergency.

5. You may also want to save a copy of your form in your electronic healthcare record, or an online personal health records application, program, or service that allows you to share your medical documents with your physicians, family, and others who you want to take an active role in your advance care planning.

INTRODUCTION TO YOUR COLORADO ADVANCE HEALTH CARE DIRECTIVE

This packet contains a legal document that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself.

Part One. The **Colorado Medical Durable Power of Attorney** lets you name someone, called an agent, to make decisions about your medical care including decisions about life support if you can no longer speak for yourself. The Medical Durable Power of Attorney is especially useful because it appoints an agent to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Part Two. The **Colorado Declaration** is your state's living will. It lets you state your wishes about medical care in the event that you develop a terminal condition or are in a persistent vegetative state.

Part Three contains the signature and witness provisions so that your document will be effective.

You may complete Part One, Part Two, or both, depending on your advance planning needs. **You must complete Part Three.**

Following your Colorado Advance Medical Directive is a **Colorado Organ Donation form**, which allows you to set out your wishes regarding organ donation. This can be especially helpful if you have not appointed an agent in Part One of your Colorado Advance Medical Directive to communicate those wishes for you.

How do I make my Colorado Advance Health Care Directive legal?

You must sign your advance medical directive in the presence of two witnesses. If you cannot do so yourself, you may direct someone to sign your advance medical directive for you.

The person signing on your behalf, at your direction, **cannot** be:

- A physician,
- An employee of your attending physician or of a health care facility in which you are a patient when you sign your document,
- A person with a claim against your estate, or
- A person entitled to any portion of your estate.

These witnesses **cannot** be:

- A person signing the document at your direction,
- A physician,

- An employee of your attending physician or of a health care facility in which you are a patient when you sign your document,
- A person with a claim against your estate, or
- A person entitled to any portion of your estate.

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your healthcare if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making healthcare decisions for you.

You can appoint a second and third person as your alternate agents. An alternate agent will step in if the person(s) you name as agent is/are unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my advance directive?

Yes! One of the most important reasons to execute an advance directive is to have your voice heard. When you name an agent and clearly communicate to them what you want and don't want, they are in the strongest position to advocate for you. Because the future is unpredictable, be careful that you do not unintentionally restrict your agent's power to act in your best interest. Be especially careful with the words "always" and "never." In any event, be sure to talk with your agent and others about your future healthcare and describe what you consider to be an acceptable "quality of life."

When does my agent's authority become effective?

Part 1, **Colorado Medical Durable Power of Attorney,** takes effect when your doctor certifies that you are unable to provide informed consent to or refusal of medical treatment or the ability to make an informed healthcare benefit decision.

Part 2, **Declaration**, becomes effective when your doctor and one other doctor certify that you have developed a terminal condition or are in a persistent vegetative state and you lack the decisional capacity to accept or reject medical or surgical treatment. Decisional capacity means the ability to provide informed consent to or refusal of medical treatment or the ability to make an informed health care benefit decision.

You retain the primary authority for your healthcare decisions as long as you are able to make your wishes known.

Agent Limitations

Your agent will be bound by the current laws of Colorado as they regard pregnancy and termination of pregnancies.

What if I change my mind?

You may revoke your Declaration orally, in writing, or by burning, tearing, canceling, obliterating, or destroying the document. Your doctor must be notified of your revocation for it to be effective. Your agent must be notified for revocation of his/her authority to be effective.

Unless you specify otherwise in your Declaration (Part Two), if you designate your spouse as your agent, that designation will automatically be revoked by divorce, dissolution or annulment of your marriage, or by a legal separation from your spouse.

Mental Health Issues

These forms do not *expressly* address mental illness, although you can state your wishes and grant authority to your agent regarding mental health issues. The National Resource Center on Psychiatric Advance Directives maintains a website (https://nrc-pad.org/) with links to each state's psychiatric advance directive forms. If you would like to make more detailed advance care plans regarding mental illness, you could talk to your physician and an attorney about a durable power of attorney tailored to your needs.

What other important facts should I know?

Your **Declaration** (Part Two) will not be honored while you are pregnant with a potentially viable fetus.

Be aware that your advance directive will not be effective in the event of a medical emergency, except to identify your agent. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless you have a separate physician's order, which are typically called "prehospital medical care directives" or "do not resuscitate orders." DNR forms may be obtained from your state health department or department of aging (https://www.hhs.gov/aging/state-resources/index.html). Another form of orders regarding CPR and other treatments are state-specific POLST (portable orders for life sustaining treatment) (https://polst.org/form-patients/). Both a POLST and a DNR form MUST be signed by a healthcare provider and MUST be presented to the emergency responders when they arrive. These directives instruct ambulance and hospital emergency personnel not to attempt CPR (or to stop it if it has begun) if your heart or breathing should stop.

INSTRUCTIONS

PRINT YOUR NAME

PRINT THE NAME, HOME ADDRESS, AND HOME AND WORK TELEPHONE NUMBERS OF YOUR AGENT

PRINT THE NAME, HOME ADDRESS, AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST AND SECOND ALTERNATE AGENTS

Part One. Medical Durable Power of Attorney

I,_____, hereby
(your name)
appoint:

_____
(name of agent)

_____
(home address of agent)

_____
(work telephone number) (home telephone number)

as my agent to make health care decisions for me if and when I do not have the capacity to make my own health care decisions. This gives my agent the power to consent to giving, withholding, or stopping any health care, treatment, service, or diagnostic procedure. My agent also has the authority to talk with health care personnel about my condition, access my medical records, get information, and sign forms necessary to carry out those decisions. If the person named as my agent is not available or is unable or unwilling to act as my agent, then I appoint the following person(s) to serve in the order listed below:

1._____
(name of first alternate)

_____
(home address)

_____
(work telephone number) (home telephone number)

2._____
(name of second alternate)

_____
(home address)

_____
(work telephone number) (home telephone number)

By this document I intend to create a Medical Durable Power of Attorney which shall take effect upon my incapacity to make my own health care decisions and shall continue during that incapacity.

When making health care decisions for me, my agent should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in Part Two (if I have filled out Part Two), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

(a) Additional Instruction:

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

INSTRUCTIONS

PRINT YOUR NAME

INITIAL ONLY ONE OPTION THAT REFLECTS YOUR WISHES

IF YOU INITIAL THE SECOND CHOICE, YOU MUST CHOOSE THE NUMBER OF DAYS YOU WANT LIFE-SUSTAINING PROCEDURES CONTINUED

Part Two. Declaration

I,_____,
(name)

being of sound mind and at least eighteen years of age, direct that my life shall not be artificially prolonged under the circumstances set forth below and hereby declare that:

If at any time my attending physician and one other qualified physician certify in writing that:

a. I have an injury, disease, or illness which is a terminal condition for which the administration of life-sustaining procedures will only serve to prolong the dying process and I am unable to make health care decisions, or

b. I am in a persistent vegetative state,

I direct that, in accordance with Colorado law, life-sustaining procedures shall be (Initial only the option that applies)

_____ (Initials) I direct that life-sustaining procedures shall be withdrawn and/or withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nourishment considered necessary by the attending physician to provide comfort or alleviate pain.

_____(Initials) I direct that life-sustaining procedures shall be continued for a period of not less than_____days, and if there be no change in my condition which would indicate to my physicians that my prognosis has improved, then I direct that life-sustaining procedures shall be withdrawn and/or withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nourishment considered necessary by the attending physician to provide comfort or alleviate pain.

_____ (Initials) I direct that life-sustaining procedures shall be continued indefinitely, regardless of my prognosis.

INITIAL ONLY ONE

IF YOU INITIAL THE SECOND CHOICE, YOU MUST CHOOSE THE NUMBER OF DAYS YOU WANT ARTIFICIAL NOURISHMENT CONTINUED

ADD OTHER INSTRUCTIONS, IF ANY, REGARDING YOUR ADVANCE CARE PLANS

THESE INSTRUCTIONS CAN FURTHER ADDRESS YOUR HEALTH CARE PLANS, SUCH AS YOUR WISHES REGARDING HOSPICE TREATMENT, BUT CAN ALSO ADDRESS OTHER ADVANCE PLANNING ISSUES, SUCH AS YOUR BURIAL WISHES

ATTACH ADDITIONAL PAGES IF NEEDED

In the event that the only procedure I am being provided is artificial nourishment, I direct that one of the following actions be taken: (initial the option that applies)

_____(Initials) Artificial nourishment shall not be continued when it is the only procedure being provided; or

_____(Initials) Artificial nourishment shall be continued for _____ days when it is the only procedure being provided; or

_____(Initials) Artificial nourishment shall be continued indefinitely when it is the only procedure being provided.

I further direct that:

_____

_____

_____

_____

_____

_____

_____

_____

_____

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 agent (if any), 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.

Part Three. Execution.

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature:_____

Date:_____

Address:_____

WITNESSING PROCEDURE

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES

WITNESSES

I declare that the person who signed or acknowledged this document ("the patient") is personally known to me, that he/she signed or acknowledged this Advance Medical Directive in my presence, and that he/she appears to be of sound mind and under no duress, fraud or undue influence. I did not sign this document for the patient. I am not the person appointed as the agent by this document. I am not a physician, nor am I the patient's health care provider, or an employee of the patient's health care provider. I have no claim on, nor am I entitled to, any portion of the patient's estate.

WITNESS #1

First Witness' Signature_____

Date_____

Print Name _____

WITNESS #2

Second Witness' Signature_____

Date_____

Print Name _____

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ORGAN DONATION (OPTIONAL)

INITIAL THE OPTION THAT REFLECTS YOUR WISHES

ADD NAME OR INSTITUTION (IF ANY)

PRINT YOUR NAME, SIGN, AND DATE THE DOCUMENT

YOUR WITNESSES MUST SIGN AND PRINT THEIR ADDRESSES

AT LEAST ONE WITNESS MUST BE A DISINTERESTED PARTY

COLORADO ORGAN DONATION FORM - PAGE 1 OF 1

Initial the line next to the statement below that best reflects your wishes. You do not have to initial any of the statements. If you do not initial any of the statements, your attorney for health care, proxy, or other agent, or your family, may have the authority to make a gift of all or part of your body under Colorado law.

_____ I do not want to make an organ or tissue donation, and I do not want my attorney for health care, proxy, or other agent or family to do so.

_____ I have already signed a written agreement or donor card regarding organ and tissue donation with the following individual or institution:

Name of individual/institution:_____

_____ Pursuant to Colorado law, I hereby give, effective on my death:

_____ Any needed organ or parts.
_____ The following part or organs listed below:

For (initial one):

_____ Any legally authorized purpose.
_____ Transplant or therapeutic purposes only.

Declarant name: _____

Declarant signature: _____ Date: _____

The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness_____Date_____

Address _____

_____

I am a disinterested party with regard to the declarant and his or her donation and estate. The declarant voluntarily signed or directed another person to sign this writing in my presence.

Witness_____Date_____

Address _____

_____

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