Personal Planning Guide

SIH Foundation

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On The Record

"My father was very good about keeping necessary personal and financial information. Unfortunately, he did not keep it in the same location. Once he took ill and was diagnosed with cancer his health never allowed him to leave the hospital and he passed away a few weeks later. Fortunately, he had worked years earlier with an attorney to create a trust in the event of his death. But locating and pulling together all the needed personal and financial information upon his death became an additional challenge and stress to the family that could have easily been avoided with some pre-planning. Years later we are still searching for those allusive original stock certificates."

When you spend more time organizing your financial estate plans, everyone benefits. These plans take a variety of forms – with additional planning options available each year. Having all the information regarding your estate compiled in one place can be beneficial as you make your estate plans today and as a record for future reference. In the event of poor health or death it will be a great aide to your benefactors and/or executor of your estate.

No matter how young or old, this guide is designed to serve a number of purposes. At a glance you will be able to locate most of your important information regarding your estate and other financial history. Family and medical history can also be recorded for reference. Completing the record will help you identify what important information is missing and provide you a central location to record and maintain that data once it is obtained. Keep it in a safe place and continue to update the record as information may change over time.

When working on your estate, financial and tax planning objectives, this record will serve as a valuable resource. Use it as a guide to integrate charitable gifts into your overall planning objectives. This will maximize benefits to both you and the charity. Make sure your loved ones know the location of the guide and how to access it.

As your plan unfolds, please consider ways that you can leave a legacy to help Southern Illinois Healthcare's hospitals, clinics and programs continue to provide superior patient care for southern Illinoisans for many years to come.

If we can be of any assistance in your planning, or answer any questions, please call our Development Office at 618-457-5200 ext. 67843 or email us at giving.info@sih.net. There are no fees and no obligations as we are here to assist your planning needs. Your support is always appreciated.

Personal History

_____
Full legal name

_____
Full legal name

Date _____/_____/_____ *Last updated*_____

Primary Address _____
Phone _____
Email _____

Person(s) to notify in case of emergency:
Name _____
Address _____
Phone _____
Email _____

Name _____
Address _____
Phone _____
Email _____

Citizenship Information

Date of Birth _____
Social Security # _____
Place of Birth _____
Birth Certificate # _____
Location of Documents _____

Passport #/Location _____

Medical Information

Primary Physician _____
Phone _____

Dentist _____
Phone _____

Special medications and/or conditions _____

_____

_____

_____

Organ donor ☐ Yes ☐ No

I have executed the following Advanced Directives:

- ☐ Power of Attorney for Healthcare
- ☐ Living Will
- ☐ Power of Attorney for Property
- ☐ Do Not Resuscitate Order

Family History

Spouse's/Partner's name _____

Address _____

Father's name _____

Mother's name _____

Maiden name (if applicable) _____

Children's names, birthdates, addresses

_____

_____

_____

_____

_____

_____

_____

Grandchildren's names, birthdates, addresses

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Employment/Income Information

Latest Employer:

Address _____

Phone _____

Dates of employment _____

Position _____

Employment Benefits

check all that apply

- ☐ Major medical insurance
- ☐ Accident and health insurance
- ☐ Life insurance
- ☐ Stock option
- ☐ Pension or deferred compensation plan
- ☐ Profit sharing
- ☐ Other _____

Contact for benefits _____

Location of benefits/files _____

Prior Employment Benefits

Previous employer _____

Contact/phone _____

Benefits that remain in effect _____

Military Service

Branch of service _____

Dates of service _____

Rank _____ Service# _____

Discharge date _____

Service-connected disability and income _____

Pensions due _____

Honors and Achievements

_____

_____

_____

_____

_____

_____

_____

Employment Benefits

Income Sources

Sources of income should include salary, Social Security, annuities, securities, trusts, pensions, profit-sharing plans, Individual Retirement Accounts (IRA's), Keogh plans, mortgages, rents, or other payments owed to you.

Source — Amount of Annual Income

_____ $_____
_____ $_____
_____ $_____
_____ $_____
_____ $_____
_____ $_____
_____ $_____
_____ $_____

Current Liabilities

Credit Cards — Account # — Balance Due

_____ _____ $ _____
_____ _____ $ _____
_____ _____ $ _____
_____ _____ $ _____

Other Loans — Account # — Balance Due

_____ _____ $ _____
_____ _____ $ _____
_____ _____ $ _____
_____ _____ $ _____

Income Tax Records

Location _____
Tax advisor/preparer _____
Phone _____

Property and Other Tax Records

Location _____
Years covered _____
Address _____

Assets

Bank Accounts

Financial Institution/Account Number — Type of Account/Current Balance

1. _____ _____
_____ $ _____
2. _____ _____
_____ $ _____
3. _____ _____
_____ $ _____
4. _____ _____
_____ $ _____

Certificates of Deposits/Other Investments

Financial Institution/Account Number — Type of Account/Current Value

1. _____ _____
_____ $ _____
2. _____ _____
_____ $ _____
3. _____ _____
_____ $ _____

Special information related to ownership of above:

_____
_____

Individual Retirement Plans

Individual Retirement Accounts/Keogh Plans

Type of Plan — Financial Institution/ Address/Representative — Value

1. _____ _____ $ _____
_____
2. _____ _____ $ _____
_____
3. _____ _____ $ _____
_____
4. _____ _____ $ _____
_____

Refer to page 6 on company-sponsored plans

Securities/Bonds/Mutual Funds

Asset _____
Investment Company _____
Representative _____ Phone _____
Date Acquired _____
Cost of Basis $ _____ Current value $ _____
Location of Documents _____

Asset _____
Investment Company _____
Representative _____ Phone _____
Date Acquired _____
Cost of Basis $ _____ Current value $ _____
Location of Documents _____

Real Estate Holdings

Description of property _____
City/State/County _____
Purchase date _____ Cost $ _____
Nature of title _____
Mortgage balance $ _____
If joint ownership, with whom _____
Location of documents _____

Description of property _____
City/State/County _____
Purchase date _____ Cost $ _____
Nature of title _____
Mortgage balance $ _____
If joint ownership, with whom _____
Location of documents _____

Attach any additional real estate holdings

Other Assets

Description _____
Location _____
Original Cost $ _____ Current value $ _____

Description _____
Location _____
Original Cost $ _____ Current value $ _____

Insurance Policies

Life
Company/agent _____
Phone _____ Policy # _____
Value $ _____

Company/agent _____
Phone _____ Policy # _____
Value $ _____

Health/Accident
Company/agent _____
Phone _____ Policy # _____
Coverage _____

Disability
Company/agent _____
Phone _____ Policy # _____
Coverage _____

Automobiles
Company/agent _____
Phone _____ Policy # _____
Coverage _____

Homeowners
Company/agent _____
Phone _____ Policy # _____
Coverage _____

Other
Company/agent _____
Phone _____ Policy # _____
Coverage _____

Personal Property of Value

Automobiles, furniture, jewelry, collectibles, artwork, etc.

Item _____
Location _____ Fair market value $ _____

Item _____
Location _____ Fair market value $ _____

Item _____
Location _____ Fair market value $ _____

Attach additional listings and/or photos as needed in back folder

Location of safe-deposit box(es) and/keys for access:

_____

_____

_____

Business Interests

Business Information: Proprietorship, partnership, corporation, etc.

Description _____ Share of Ownership _____

_____ _____

_____ _____

Persons to contact regarding business interests (attorneys, accountants, financial advisors)

Name _____

Business _____

Address _____ Phone _____

Name _____

Business _____

Address _____ Phone _____

Leaving a Legacy

You play an important role in the future of health care in your community. You understand that SIH hospitals, clinics and services make an important contribution throughout the region. And, like health care institutions everywhere, SIH must look beyond its traditional sources of support and supplement revenue with private contributions in order to maintain the level of medical excellence the people of southern Illinois deserve.

Charitable Gifts through the SIH Foundation help:

- Provide financial support to fund patient care
- Supply equipment and resources to enhance services and occupational excellence
- Fund community service programs
- Provide funding for capital improvements to best serve ever-changing needs
- And so much more!

You gift makes the difference in the lives of the thousands of families who count on SIH every day for compassionate state-of-the-art care. You have the power to change a life...let us show you how.

SIH Foundation 618-457-5200 ext. 67843

Property Distribution Plans

My Will

Location of My Will _____

Date of Will _____ Last Review _____

Date(s) of any codicils or prior wills _____

Executor or personal representative _____

Address _____

Phone _____

Alternate Executor or Personal Representative _____

Address _____

Phone _____

Estate Attorney _____

Address _____

Phone _____

Beneficiaries of My Estate

Item(s)/$ amount/percentage _____

Beneficiary _____

Address _____ Phone _____

Item(s)/$ amount/percentage _____

Beneficiary _____

Address _____ Phone _____

Item(s)/$ amount/percentage _____

Beneficiary _____

Address _____ Phone _____

Item(s)/$ amount/percentage _____

Beneficiary _____

Address _____ Phone _____

Item(s)/$ amount/percentage _____

Beneficiary _____

Address _____ Phone _____

Attach additional listings in back folder

Name(s) and address(es) of guardian(s) named in my will for dependents:

Name _____

Address _____ Phone _____

Name _____

Address _____ Phone _____

Special instructions concerning pets:

_____

_____

Once you have designated beneficiaries for specific items, the remainder of your estate may be divided by percentages or dollar amounts. List beneficiaries (individuals or charity) percentage, or dollar amount each one is to receive:

Name/address of person or charity _____

Percentage/$ amount/item _____

Name/address of person or charity _____

Percentage/$ amount/item _____

Name/address of person or charity _____

Percentage/$ amount/item _____

For free assistance with bequest wording at no obligation, please call our Development Office at 618-457-5200 ext. 67843, or email giving.info@sih.net or have your attorney call.

Trusts Created by Will

Trustee _____

Address _____ Phone _____

Beneficiary(ies) _____

Location of will/trust _____

Trustee _____

Address _____ Phone _____

Beneficiary(ies) _____

Location of will/trust _____

Revocable Living Trusts

Trustee _____

Successor Trustee _____

Address _____ Phone _____

Trust assets _____

Beneficiary(ies) _____

Location of trust agreement _____

Other Trusts

Trustee _____

Successor Trustee _____

Address _____ Phone _____

Trust assets _____

Beneficiary(ies) _____

Funeral Instructions

Arrangements to be made at _____

Address _____ Phone _____

Manner of burial or cremation instructions _____

_____

_____

_____

_____

_____

_____

_____

Cemetery _____

Address _____ Phone _____

Type of service I prefer _____

_____

_____

_____

_____

_____

_____

_____

Please suggest memorial gifts to the following organizations:

Organization _____

Address _____ Phone _____

Organization _____

Address _____ Phone _____

Organization _____

Address _____ Phone _____

Calculating Your Net Worth

Taxes will shrink your estate. Use this worksheet to begin the process to find out how much. The first step is to determine your Net Worth. Once your Net Worth is established (see form below) you can work with us or your financial advisor to estimate estate settlement costs, deductions from your estate, such as charitable bequests to determine your taxable estate. The final step is to refer to the 2011 federal tax tables (page 15) to determine your preliminary federal estate tax.

If you would like assistance completing these forms, would like information on how to eliminate or reduce estate taxes, or have any questions about the benefits of wills and estate planning, please contact us.

Contact our Fund Development Office for free no obligation assistance at 618-457-5200 ext. 67843.

A. Assets

1. Cash, savings, and bank accounts	$ _____
2. Mutual funds, stocks, bonds, CD's, other	$ _____
3. Your home (current market value)	$ _____
4. Other real estate (current market value)	$ _____
5. Individually owned personal property (cars, jewelry, collectibles)	$ _____
6. Your share of jointly held property	$ _____
7. Net equity in your business	$ _____
8. Life insurance proceeds	$ _____
9. IRA's, retirement plans, annuities	$ _____
10. Total Assets (add lines 1 through 9)	**$** _____

B. Debts

11. Personal property debts (credit cards, bills)	$ _____
12. Mortgage loans	$ _____
13. Other consumer loans	$ _____
14. Income and property taxes	$ _____
15. Total Debts (add lines 11 through 14)	**$** _____

C. Net Worth

16. Total assets (line 10)	$ _____
17. Total Debts (line 15)	$ _____
18. Net Worth (line 16 minus line 17)	**$** _____

Notes

Living Will

DECLARATION

This declaration is made this _____ day of_____ (month, year).

I, _____, born on _____, being of sound mind, willfully and voluntarily make known my desires that my moment of death shall not be artificially postponed.

If at any time I should have an incurable and irreversible injury, disease, or illness judged to be a terminal condition by my attending physician who has personally examined me and has determined that my death is imminent except for death delaying procedures, I direct that such procedures which would only prolong the dying process be withheld or withdrawn, and that I be permitted to die naturally with only the administration of medication, sustenance, or the performance of any medical procedure deemed necessary by my attending physician to provide me with comfort care.

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

Signed_____

City, County and State of Residence_____

The declarant is personally known to me and I believe him or her to be of sound mind. I saw the declarant sign the declaration in my presence (or the declarant acknowledged in my presence that he or she had signed the declaration) and I signed the declaration as a witness in the presence of the declarant. I did not sign the declarant's signature above for or at the direction of the declarant. At the date of this instrument, I am not entitled to any portion of the estate of the declarant according to the laws of intestate succession or, to the best of my knowledge and belief, under any will of declarant or other instrument taking effect at declarant's death, or directly financially responsible for declarant's medical care.

Witness _____

Witness _____

History
(Source: P.A. 85-1209.)
Annotations
Note. This section was Ill.Rev.Stat., Ch. 110 1/2, Para. 703.

Rev 5/2012

State of Illinois
Illinois Department of Public Health

Illinois Statutory Short Form
Power of Attorney for Health Care

NOTICE TO THE INDIVIDUAL SIGNING THE POWER OF ATTORNEY FOR HEALTH CARE

No one can predict when a serious illness or accident might occur. When it does, you may need someone else to speak or make health care decisions for you. If you plan now, you can increase the chances that the medical treatment you get will be the treatment you want.

In Illinois, you can choose someone to be your "health care agent." Your agent is the person you trust to make health care decisions for you if you are unable or do not want to make them yourself. These decisions should be based on your personal values and wishes.

It is important to put your choice of agent in writing. The written form is often called an "advance directive." You may use this form or another form, as long as it meets the legal requirements of Illinois. There are many written and online resources to guide you and your loved ones in having a conversation about these issues. You may find it helpful to look at these resources while thinking about and discussing your advance directive.

WHAT ARE THE THINGS I WANT MY HEALTH CARE AGENT TO KNOW?

The selection of your agent should be considered carefully, as your agent will have the ultimate decision making authority once this document goes into effect - in most instances after you are no longer able to make your own decisions. While the goal is for your agent to make decisions in keeping with your preferences and in the majority of circumstances that is what happens, please know that the law does allow your agent to make decisions to direct or refuse health care interventions or withdraw treatment. Your agent will need to think about conversations you have had, your personality, and how you handled important health care issues in the past. Therefore, it is important to talk with your agent and your family about such things as:

(i) What is most important to you in your life?

(ii) How important is it to you to avoid pain and suffering?

(iii) If you had to choose, is it more important to you to live as long as possible, or to avoid prolonged suffering or disability?

(iv) Would you rather be at home or in a hospital for the last days or weeks of your life?

(v) Do you have religious, spiritual, or cultural beliefs that you want your agent and others to consider?

(vi) Do you wish to make a significant contribution to medical science after your death through organ or whole body donation?

(vii) Do you have an existing advanced directive, such as a living will, that contains your specific wishes about health care that is only delaying your death? If you have another advance directive, make sure to discuss with your agent the directive and the treatment decisions contained within that outline your preferences. Make sure that your agent agrees to honor the wishes expressed in your advance directive.

WHAT KIND OF DECISIONS CAN MY AGENT MAKE?

If there is ever a period of time when your physician determines that you cannot make your own health care decisions, or if you do not want to make your own decisions, some of the actions your agent could take are to:

(i) talk with physicians and other health care providers about your condition.

(ii) see medical records and approve who else can see them.

(iii) give permission for medical tests, medicines, surgery, or other treatments.

(iv) choose where you receive care and which physicians and others provide it.

(v) decide to accept, withdraw, or decline treatments designed to keep you alive if you are near death or not likely to recover. You may choose to include guidelines and/or restrictions to your agent's authority.

(vi) agree or decline to donate your organs or your whole body if you have not already made this decision yourself. This could include donation for transplant, research, and/or education. You should let your agent know whether you are registered as a donor in the First Person Consent registry maintained by the Illinois Secretary of State or whether you have agreed to donate your whole body for medical research and/or education.

(vii) decide what to do with your remains after you have died, if you have not already made plans.

(viii) talk with your other loved ones to help come to a decision (but your designated agent will have the final say over your other loved ones).

Your agent is not automatically responsible for your health care expenses.

WHO SHOULD I CHOOSE TO BE MY HEALTH CARE AGENT?

Your agent will have the responsibility to make medical treatment decisions, even if other people close to you might urge a different decision. The selection of your agent should be done carefully, as he or she will have ultimate decision-making authority for your treatment decisions once you are no longer able to voice your preferences. Choose a family member, friend, or other person who:

(i) is at least 18 years old;

(ii) knows you well;

(iii) you trust to do what is best for you and is willing to carry out your wishes, even if he or she may not agree with your wishes;

(iv) would be comfortable talking with and questioning your physicians and other health care providers;

(v) would not be too upset to carry out your wishes if you became very sick; and

(vi) can be there for you when you need it and is willing to accept this important role.

WHAT IF MY AGENT IS NOT AVAILABLE OR IS UNWILLING TO MAKE DECISIONS FOR ME?

If the person who is your first choice is unable to carry out this role, then the second agent you chose will make the decisions; if your second agent is not available, then the third agent you chose will make the decisions. The second and third agents are called your successor agents and they function as back-up agents to your first choice agent and may act only one at a time and in the order you list them.

WHAT WILL HAPPEN IF I DO NOT CHOOSE A HEALTH CARE AGENT?

If you become unable to make your own health care decisions and have not named an agent in writing, your physician and other health care providers will ask a family member, friend, or guardian to make decisions for you. In Illinois, a law directs which of these individuals will be consulted. In that law, each of these individuals is called a "surrogate".

There are reasons why you may want to name an agent rather than rely on a surrogate:

(i) The person or people listed by this law may not be who you would want to make decisions for you.

(ii) Some family members or friends might not be able or willing to make decisions as you would want them to.

(iii) Family members and friends may disagree with one another about the issue being decided.

(iv) Under some circumstances, a surrogate may not be able to make the same kinds of decisions that an agent can make.

WHAT IF THERE IS NO ONE AVAILABLE WHO I TRUST TO BE MY AGENT?

In this situation, it is especially important to talk to your physician and other health care providers and create written guidance about what you want or do not want, in case you are ever critically ill and cannot express your own wishes. You can complete a living will. You can also write your wishes down and/or discuss them with your physician or other health care provider and ask him or her to write it down in your chart. You might also want to use written or online resources to guide you through this process.

WHAT DO I DO WITH THIS FORM ONCE I COMPLETE IT?

Follow these instructions after you have completed the form:

(i) Sign the form in front of a witness. See the form for a list of who can and cannot witness it.

(ii) Ask the witness to sign it, too. There is no need to have the form notarized.

(iii) Give a copy to your agent and to each of your successor agents.

(iv) Give another copy to your physician.

(v) Take a copy with you when you go to the hospital.

(vi) Show it to your family and friends and others who care for you.

WHAT IF I CHANGE MY MIND?

You may change your mind at any time. If you do, tell someone who is at least 18 years old that you have changed your mind, and/or destroy your document and any copies. If you wish, fill out a new form and make sure everyone you gave the old form to has a copy of the new one, including, but not limited to your agents and your physicians.

WHAT IF I DO NOT WANT TO USE THIS FORM?

In the event you do not want to use the Illinois statutory form provided here, any document you complete must be executed by you. Designate an agent who is over 18 years of age and not prohibited from serving as your agent, and state the agent's powers. It need not be witnessed or conform in any other respect to the statutory health care power.

If you have questions about the use of any form, you may want to consult your physician, other health care provider, and/or an attorney.

State of Illinois
Illinois Department of Public Health

Illinois Statutory Short Form
Power of Attorney for Health Care

MY POWER OF ATTORNEY FOR HEALTH CARE

THIS POWER OF ATTORNEY REVOKES ALL PREVIOUS POWERS OF ATTORNEY FOR HEALTH CARE.

My name (Print your full name): _____

My address: _____

I WANT THE FOLLOWING PERSON TO BE MY HEALTH CARE AGENT (an agent is your personal representative under state and federal law):

(Agent name) _____

(Agent address) _____

(Agent phone number) _____

MY AGENT CAN MAKE HEALTH CARE DECISIONS FOR ME, INCLUDING:

(i) Deciding to accept, withdraw, or decline treatment for any physical or mental condition of mine, including life-and-death decisions.

(ii) Agreeing to admit me to or discharge me from any hospital, home, or other institution, including a mental health facility.

(iii) Having complete access to my medical and mental health records, and sharing them with others as needed, including after I die.

(iv) Carrying out the plans I have already made, or, if I have not done so, making decisions about my body or remains, including organ, tissue, or whole body donation, autopsy, cremation, and burial.

The above grant of power is intended to be as broad as possible so that my agent will have the authority to make any decision I could make to obtain or terminate any type of health care, including withdrawal of nutrition and hydration and other life-sustaining measures.

I AUTHORIZE MY AGENT TO: (Please check only one box; if more than one box or no boxes are checked, the directive in the first box below shall be implemented.)

❑ Make decisions for me only when I cannot make them for myself. The physician(s) taking care of me will determine when I lack this ability.

❑ Make decisions for me starting now and continue after I am no longer able to make them for myself. While I am still able to make my own decisions, I can still do so if I want to.

LIFE-SUSTAINING TREATMENTS

The subject of life-sustaining treatment is of particular importance. Life-sustaining treatments may include tube feedings or fluids through a tube, breathing machines, and CPR. In general, in making decisions concerning life-sustaining treatment, your agent is instructed to consider the relief of suffering, the quality as well as the possible extension of your life, and your previously expressed wishes. Your agent will weigh the burdens versus benefits of proposed treatments in making decisions on your behalf.

Additional statements concerning the withholding or removal of life-sustaining treatment are described below. These can serve as a guide for your agent when making decisions for you. Ask your physician or health care provider if you have any questions about these statements. SELECT ONLY ONE STATEMENT BELOW THAT BEST EXPRESSES YOUR WISHES **(optional)**:

- ❑ The quality of my life is more important than the length of my life. If I am unconscious and my attending physician believes, in accordance with reasonable medical standards, that I will not wake up or recover my ability to think, communicate with my family and friends, and experience my surroundings, I do not want treatments to prolong my life or delay my death, but I do want treatment or care to make me comfortable and to relieve me of pain.
- ❑ Staying alive is more important to me, no matter how sick I am, how much I am suffering, the cost of the procedures, or how unlikely my chances for recovery are. I want my life to be prolonged to the greatest extent possible in accordance with reasonable medical standards.

SPECIFIC LIMITATIONS TO MY AGENT'S DECISION-MAKING AUTHORITY:

The above grant of power is intended to be as broad as possible so that your agent will have the authority to make any decision you could make to obtain or terminate any type of health care. If you wish to limit the scope of your agent's powers or prescribe special rules or limit the power to authorize autopsy or dispose of remains, you may do so specifically on the lines below or add another page if needed:

_____

_____

_____

_____

YOU MUST SIGN THIS FORM, AND A WITNESS MUST ALSO SIGN IT BEFORE IT IS VALID.

My signature: _____ Today's date: _____

HAVE YOUR WITNESS COMPLETE THE FOLLOWING AND SIGN:

I am at least 18 years old, and (check one of the options below):

- ❑ I saw the principal sign this document, or
- ❑ The principal told me that the signature or mark on the principal signature line is his or hers.

I am not the agent or successor agent(s) named in this document. I am not related to the principal, the agent, or the successor agent(s) by blood, marriage, or adoption. I am not the principal's physician, mental health service provider, or a relative of one of those individuals. I am not an owner or operator (or the relative of an owner or operator) of the health care facility where the principal is a patient or resident.

Witness printed name: _____

Witness address: _____

Witness signature: _____ Today's date: _____

SUCCESSOR HEALTH CARE AGENT(S) (optional):

If the agent I have selected is unable or does not want to make health care decisions for me, then I request the person(s) I name below to be my successor health care agent(s). Only one person at a time can serve as my agent (add another page if you want to add more successor agent names):

_____

(Successor agent #1 name, address and phone number)

_____

(Successor agent #2 name, address and phone number)

State of Illinois
Illinois Department of Public Health

DO-NOT-RESUSCITATE (DNR)/PRACTITIONER ORDERS FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

For patients, use of this form is completely voluntary. Follow these orders until changed. These medical orders are based on the patient's medical condition and preferences. Any section not completed does not invalidate the form and implies initiating all treatment for that section. With significant change of condition new orders may need to be written.

Patient Last Name	Patient First Name	MI

Date of Birth (mm/dd/yy)	Gender ❑ M ❑ F

Address (street/city/state/ZIPcode)

A — CARDIOPULMONARY RESUSCITATION (CPR) If patient has no pulse and is not breathing.

Check One

❑ **Attempt Resuscitation/CPR** ❑ **Do Not Attempt Resuscitation/DNR**

(*Selecting CPR means* **Full Treatment** *in Section B is selected*)

When not in cardiopulmonary arrest, follow orders B and C.

B — MEDICAL INTERVENTIONS If patient is found with a pulse and/or is breathing.

Check One *(optional)*

❑ **Full Treatment: Primary goal of sustaining life by medically indicated means.** In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, mechanical ventilation and cardioversion as indicated. *Transfer to hospital and/or intensive care unit if indicated.*

❑ **Selective Treatment: Primary goal of treating medical conditions with selected medical measures.** In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV fluids and IV medications (may include antibiotics and vasopressors), as medically appropriate and consistent with patient preference. Do Not Intubate. May consider less invasive airway support (e.g. CPAP, BiPAP). *Transfer to hospital, if indicated. Generally avoid the intensive care unit.*

❑ **Comfort-Focused Treatment: Primary goal of maximizing comfort.** Relieve pain and suffering through the use of medication by any route as needed; use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. ***Request transfer to hospital only if comfort needs cannot be met in current location.***

Optional Additional Orders _____

C — MEDICALLY ADMINISTERED NUTRITION (if medically indicated) Offer food by mouth, if feasible and as desired.

Check One *(optional)*

❑ Long-term medically administered nutrition, including feeding tubes.

❑ Trial period of medically administered nutrition, including feeding tubes.

❑ No medically administered means of nutrition, including feeding tubes.

Additional Instructions (e.g., length of trial period)

_____

_____

D — DOCUMENTATION OF DISCUSSION (Check all appropriate boxes below)

❑ Patient ❑ Agent under health care power of attorney

❑ Parent of minor ❑ Health care surrogate decision maker (See Page 2 for priority list)

Signature of Patient or Legal Representative

Signature ***(required)***	Name (print)	Date

Signature of Witness to Consent (Witness required for a valid form)

I am 18 years of age or older and acknowledge the above person has had an opportunity to read this form and have witnessed the giving of consent by the above person or the above person has acknowledged his/her signature or mark on this form in my presence.

Signature ***(required)***	Name (print)	Date

E — Signature of Attending Practitioner (physician, licensed resident (second year or higher), advanced practice nurse or physician assistant)

My signature below indicates to the best of my knowledge and belief that these orders are consistent with the patient's medical condition and preferences.

Print Attending Practitioner Name ***(required)***	Phone ( ) _____ - _____

Attending Practitioner Signature ***(required)***	Date ***(required)***

Form Revision Date January 2015 **(Prior form versions are also valid.)**

THIS SIDE FOR INFORMATIONAL PURPOSES ONLY		
Patient Last Name	Patient First Name	MI

The Illinois Department of Public Health (IDPH) Do Not Resuscitate (DNR)/Practitioner Orders for Life Sustaining Treatment (POLST) **is always voluntary**. This order records your wishes for medical treatment in your current state of health. Once initial medical treatment is begun and the risks and benefits of further therapy are clear, your treatment wishes may change. Your medical care and this form can be changed to reflect your new wishes at any time. However, no form can address all the medical treatment decisions that may need to be made. The Power of Attorney for Health Care Advance Directive form (POAHC) is recommended for all capable adults, regardless of their health status. A POAHC allows you to document, in detail, your future health care instructions and name a Legal Representative to speak for you if you are unable to speak for yourself.

Advance Directive Information		
I also have the following advance directives (OPTIONAL)		
❑ Health Care Power of Attorney	❑ Living Will Declaration	❑ Mental Health Treatment Preference Declaration
Contact Person Name		Contact Phone Number

Health Care Professional Information	
Preparer Name	Phone Number
Preparer Title	Date Prepared

Completing the IDPH Do Not Resuscitate (DNR)/POLST Form

- **The completion of a DNR/POLST form is always voluntary, cannot be mandated and may be changed at any time.**
- A DNR/POLST should reflect current preferences of persons completing the DNR/POLST Form; encourage completion of a POAHC.
- Verbal/phone orders are acceptable with follow-up signature by attending physician in accordance with facility/community policy.
- Use of original form is encouraged. Photocopies and faxes on any color of paper also are legal and valid forms.

Reviewing a Do Not Resuscitate (DNR)/POLST Form

This DNR/POLST form should be reviewed periodically and if:

- The patient is transferred from one care setting or care level to another,
- or there is a substantial change in the patient's health status,
- or the patient's treatment preferences change,
- or the patient's primary care professional changes.

Voiding or revoking a Do Not Resuscitate (DNR)/POLST Form

- A patient with capacity can void or revoke the form, and/or request alternative treatment.
- Changing, modifying or revising a DNR/POLST form requires completion of a new DNR/POLST form.
- Draw line through sections A through E and write "VOID" across page if any DNR/POLST form is replaced or becomes invalid. Beneath the written "VOID" write in the date of change and re-sign.
- If included in an electronic medical record, follow all voiding procedures of facility.

Illinois Health Care Surrogate Act (755 ILCS 40/25) Priority Order

1. Patient's guardian of person
2. Patient's spouse or partner of a registered civil union
3. Adult child
4. Parent
5. Adult sibling
6. Adult grandchild
7. A close friend of the patient
8. The patient's guardian of the estate

For more information, visit the IDPH Statement of Illinois law at
http://www.idph.state.il.us/public/books/advin.htm

HIPAA (HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996) PERMITS DISCLOSURE TO HEALTH CARE PROFESSIONALS AS NECESSARY FOR TREATMENT

Notes