PART I

PART I. DURABLE POWER OF ATTORNEY FOR HEALTH CARE

PRINT YOUR NAME AND ADDRESS

I, _____, of
(name of principal)

_____
(address)

PRINT THE NAME, ADDRESS, AND TELEPHONE NUMBER OF YOUR AGENT

hereby appoint _____, of
(name of agent)

_____

_____
(address and telephone number of agent)

As my attorney-in-fact ("agent") to consent to, to reject, or to withdraw consent for medical procedures, treatment, or intervention.

2) In the event the person I appoint above is unable, unwilling or unavailable to act as my health care agent, I hereby appoint as my successor agent:

PRINT THE NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR ALTERNATE AGENT

_____, of
(name of successor agent)

_____

_____
(address and telephone number of successor agent)

3) I have discussed my wishes with my agent and my successor agent, and authorize him/her to make all and any health care decisions for me, including decisions to withhold or withdraw any form of life support. I expressly authorize my agent (and successor agent) to make decisions for me regarding the withholding or withdrawal of artificial nutrition and hydration in all medical circumstances.

4) This power of attorney becomes effective when I can no longer make my own medical decisions, and is not affected by physical disability or mental incompetence. The determination of whether I can make my own medical decisions is to be made by my agent, or if he or she is unable, unwilling or unavailable to act, by my successor agent, unless the attending physician determines that I have decisional capacity.

5) 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 this document, 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 agent should make decisions for me that my agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

I give the following instructions to help guide my agent:

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(attach additional pages if needed)

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

PART II

PART II. DECLARATION

Notice

This is an important legal document. A living will directs the medical treatment you are to receive in the event you are in a terminal condition and are unable to participate in your own medical decisions. This living will may state what kind of treatment you want or do not want to receive.

NOTICE

Prepare this document carefully. If you use this form, read it completely. You may want to seek professional help to make sure the form does what you intend and is completed without mistakes.

This document will remain valid and in effect until and unless you revoke it. Review this document periodically to make sure it continues to reflect your wishes. You may amend or revoke this document at any time by notifying your physician and other health care providers. You should give copies of this document to your family, your physician and your health care facility. This form is entirely optional. If you choose to use this form, please note that the form provides signature lines for you, the two witnesses whom you have selected and a notary public.

PRINT YOUR NAME

TO MY FAMILY, HEALTH CARE PROVIDER, AND ALL THOSE CONCERNED WITH MY CARE:

I, _____,
direct that you follow my wishes for care if I am in a terminal condition, my death is imminent, and I am unable to communicate my decisions about my medical care.

With respect to any life-sustaining treatment, I direct the following:

LIFE-SUSTAINING TREATMENT CHOICES

(Initial only one of the following optional options. If you do not agree with either of the following options, space is provided below for you to write your own instructions).

INITIAL ONLY ONE

_____ If my death is imminent, I choose not to prolong my life. If life sustaining treatment has been started, stop it, but keep me comfortable and control my pain.

_____ Even if my death is imminent, I choose to prolong my life.

_____ I choose neither of the above options, and here are my instructions should I become terminally ill and my death is imminent:

_____

_____

_____

_____

With respect to artificial nutrition and hydration, I direct the following

ARTIFICIAL NUTRITION AND HYDRATION CHOICES

(Artificial nutrition and hydration means food and water provided by means of a tube inserted into the stomach or intestine or needle into a vein.)

INITIAL ONLY ONE

(initial only one):

_____ If my death is imminent, I do not want artificial nutrition land hydration. If it has been started, stop it.

_____ Even if my death is imminent, I want artificial nutrition and hydration.

PART III

SIGN, DATE, AND PRINT YOUR NAME AND ADDRESS

IF YOU COMPLETED PART II, YOU MUST HAVE YOUR SIGNATURE WITNESSED

IN ANY EVENT IT IS A GOOD IDEA TO HAVE YOUR SIGNATURE WITNESSED, EVEN IF YOU HAVE COMPLETED ONLY PART I

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES AND ADDRESSES HERE

THIS OPTIONAL SECTION IS TO BE COMPLETED BY A NOTARY PUBLIC

PART III. EXECUTION

Signature:_____ Date:_____

Printed Name:_____

Address:_____

WITNESSES

The declarant voluntarily signed this document in my presence.

Witness Signature:_____ Date:_____

Printed Name:_____

Address: _____

_____

Witness Signature:_____ Date:_____

Printed Name:_____

Address: _____

_____

NOTARY (OPTIONAL)

On this the _____ day of _____, _____, the declarant,

_____, and

witnesses_____ and _____,

personally appeared before the undersigned officer and signed the foregoing instrument in my presence.

Dated this _____ day of _____, _____.

_____

Notary Public

My Commission expires: _____

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

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

SOUTH DAKOTA 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 South Dakota 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 South Dakota 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 _____

_____

Courtesy of Caring Connections
1731 King St., Suite 100, Alexandria, VA 22314
www.caringinfo.org, 800/658-8898

You Have Filled Out Your Health Care Directive, Now What?

1. Your *South Dakota Advance Directive* is an important legal document. Keep the original signed document in a secure but accessible place. Do not put the original document in a safe deposit box or any other security box that would keep others from having access to it.

2. Give photocopies of the signed original to your agent and alternate agent, doctor(s), family, close friends, clergy, and anyone else who might become involved in your health care. If you enter a nursing home or hospital, have photocopies of your document placed in your medical records.

3. Be sure to talk to your agent(s), doctor(s), clergy, family, and friends about your wishes concerning medical treatment. Discuss your wishes with them often, particularly if your medical condition changes.

4. South Dakota does not maintain an Advance Directive Registry. However you may record a durable power of attorney for health care (Part I of this form) at your county's register of deeds. Be aware that, if you do record your advance directive, you will also need to record any revocation you make as well.

5. You may also want to save a copy of your form in 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.

6. If you want to make changes to your documents after they have been signed and witnessed, you must complete a new document.

7. Remember, you can always revoke your South Dakota document.

8. Be aware that your South Dakota document will not be effective in the event of a medical emergency. Ambulance and hospital emergency department personnel are required to provide cardiopulmonary resuscitation (CPR) unless they are given a separate directive that states otherwise. These directives called "prehospital medical care directives" or "do not resuscitate orders" are designed for people whose poor health gives them little chance of benefiting from CPR. These directives instruct ambulance and hospital emergency personnel not to attempt CPR if your heart or breathing should stop.

   Currently not all states have laws authorizing these orders. We suggest you speak to your physician if you are interested in obtaining one. **Caring Connections does not distribute these forms.**