DURABLE POWER OF ATTORNEY
(WITH HEALTH CARE POWERS ONLY)

NOTICE: **The powers granted by this document are broad and sweeping. They are explained in the Uniform Statutory Form Power of Attorney Act. If you have any questions about these powers, obtain competent legal advice. Free legal information regarding construction of the powers granted by this document and completion of this form may be obtained by calling the Legal Services Developer, Aging Services Division of the Oklahoma Department of Human Services, (405) 522-3069, or your local legal aid or legal services office. This document authorizes your agent to make medical and other health-care decisions for you. You may revoke this power of attorney if you later wish to do so.**

I _____

(insert name and address)

appoint _____

(insert name and address of the person appointed)

as my agent (attorney-in-fact) to act for me in any lawful way with respect to the following initialed subjects. If my agent is unable or unwilling to serve, I appoint _____

_____

(insert name and address)

as my alternate agent with the same authority.

Once effective pursuant to section III on the back of this form, this power of attorney will continue to be effective even though I become disabled, incapacitated, or incompetent, and shall not be affected by lapse of time.

I. Grant of Health Care Powers

To grant all of the following powers, initial the line in front of (f) and ignore the lines in front of the other powers.

To grant one or more, but fewer than all, of the following powers, initial the line in front of each power you are granting.

To withhold a power, do not initial the line in front of it. You may, but need not, cross out each power withheld.

1. If I am unable to decide or speak for myself, my agent has the power to:

Initial

_____ a. Make health and medical care decisions for me, including serving as my representative under the Oklahoma Do-Not-Resuscitate Act, but excluding signing an advance directive, making decisions reserved to a health care proxy under an advance directive, or other life-sustaining treatment decisions.

_____ b. Choose my health care providers.

_____ c. Choose where I live and receive care and support when these choices relate to my health care needs.

_____ d. Review my medical records and have the same rights that I would have to give my medical records to other people.

_____ e. Elect hospice treatment.

_____ f. All of the powers listed above.

You need not initial any other lines if you initial line f.

2. It is my intention that my agent's acts on my behalf are to be honored by my family members and health care providers as an expression of my legal right to manage my health care. The directions and decisions of my agent are superior to and shall take precedence over any decision made by any member of my family. To the extent appropriate, my agent may discuss health care decisions with my family and others to the extent they are available.

II. Additional Guidance and Information

NOTE: **This section, while very helpful to your agent, is optional and choices may be left blank.**

a. My goals for my health care:_____

_____

b. My fears about my health care:_____

_____

_____

c. My spiritual or religious beliefs and traditions:_____

_____

_____

d. My thoughts about how my medical condition might affect my family: _____

_____

_____

e. My thoughts about living and receiving health care at home versus in a nursing home or other institution: _____

_____

Special Instructions: On the following lines you may give special instructions limiting or extending the powers granted to your agent. _____

_____

_____

_____

_____

(Attach additional pages if needed.)

III. When Power Becomes Effective

Please initial one statement below regarding the effective date of this power of attorney.

Initial

_____ This power of attorney is effective immediately and shall continue until it is revoked.

_____ This power of attorney shall be effective when my attending physician determines that I am no longer able to manage my person. This determination shall be provided in writing and attached to this form.

I agree that any third party who receives a copy of this document may act under it. Revocation of the power of attorney is not effective as to a third party until the third party learns of the revocation. I agree to indemnify the third party for any claims that arise against the third party because of reliance on this power of attorney.

Signed: _____

(Principal's signature)

City, County, and State of Residence

_____

The principal is personally known to me and I believe the principal to be of sound mind. I am eighteen (18) years of age or older. I am not related to the principal by blood or marriage, or related to the attorney-in-fact by blood or marriage. The principal has declared to me that this instrument is his power of attorney granting to the named attorney-in-fact the power and authority specified herein, and that he has willingly made and executed it as his free and voluntary act for the purposes herein expressed.

Witness: _____

Witness: _____

STATE OF OKLAHOMA)
) SS.
COUNTY OF _____)

Before me, the undersigned authority, on this _____ day of _____, 20____, personally appeared _____ (principal), _____ (witness), and _____ (witness), whose names are subscribed to the foregoing instrument in their respective capacities, and all of said persons being by me duly sworn, the principal declared to me and to the said witnesses in my presence that the instrument is his or her power of attorney, and that the principal has willingly and voluntarily made and executed it as the free act and deed of the principal for the purposes therein expressed, and the witnesses declared to me that they were each eighteen (18) years of age or over, and that neither of them is related to the principal by blood or marriage, or related to the attorney-in-fact by blood or marriage.

_____

Notary Public

My Commission Expires: _____

By accepting or acting under the appointment, the agent assumes the fiduciary and other legal responsibilities of an agent.

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DNR GUIDE
(REVISED)

Oklahoma now has a community Do-Not-Resuscitate (DNR) consent form.

- The form is community in the sense that it may be signed at home. This is much less stressful than waiting to sign a DNR consent form at a hospital or nursing facility. Once signed, the form is portable. You may take it with you to a hospital or nursing facility and it must be honored. By signing the form, you are instructing physicians and all medical institutions who might care for you that in the event of cardiac or respiratory arrest, **you do not consent to the administration of cardiopulmonary resuscitation (CPR) in any form.**

- Signing requirements are the same as those for an advance directive: two witnesses eighteen years or older who are not named in your will. The form doesn't have to be notarized and your doctor doesn't have to co-sign.

- The bright yellow color of the form assures it will be recognized by those attending you, including emergency medical personnel. You do not have to buy a necklace or bracelet, but you may if you wish. Necklaces and bracelets will not be supplied by the Department of Human Services. If the DNR form will be used in your home, display it above your bed or on your refrigerator door.

- **IMPORTANT**: This form isn't for everyone. It is intended for use by a person who is **near death**. An advance directive doesn't go into effect until two physicians certify your condition as terminal. But the DNR consent form goes into effect **immediately**. Therefore, it should be signed only by someone who is terminal in his or her own mind and has made an informed decision that he or she does not want to be resuscitated in any circumstance.

- Those who are not near death can anticipate use of the form, however. You may appoint a representative to sign the form for you if you become incapacitated. "Representative" is defined in the law as an agent for health care decisions under a durable power of attorney, a health care proxy acting under an advance directive or a guardian of the person. If you don't sign a consent form or appoint a representative, your physician can certify that you would not have consented to CPR if he or she knows by **clear and convincing evidence** that you had decided not to be resuscitated in the event of cardiac or respiratory arrest. This certification is made on the "Certification of Physician" form on the back of the consent form, and this form is to be used **only by physicians**. Since your physician can certify your desire not to be resuscitated only if he knows this for a fact, it is important for you to discuss-and to say out loud in the presence of family or close friends-how you feel about the administration of CPR in near death situations. Your family and friends can then communicate your decision to your attending physician if you become incapacitated.

- **If you have capacity, only you may sign the form**. In fact, your doctor must record in your medical record why it is appropriate for someone other than you to be signing. For example, it would be appropriate only if you were incapacitated and you have a representative, as defined above. If you have a representative and it is appropriate for the representative to sign for you, the representative must first be informed by your doctor that **the representative is deciding what you would want if you could speak for yourself.**

- Free DNR consent forms are available and may be ordered from:

  DHS Supply Warehouse
  217 N. E. 30th Street
  Oklahoma City, OK 73105
  877-283-4113
  FAX 405-528-4991 Give your name, address, phone number and quantity.

For free legal assistance in completing the form, call Richard Ingham, Legal Services Developer, Aging Services Division of DHS,(405) 522-3069.

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OKLAHOMA DO-NOT-RESUSCITATE (DNR) CONSENT FORM

I, _____, request limited health care as described in this document. If my heart stops beating or if I stop breathing, no medical procedure to restore breathing or heart function will be instituted by any health care provider including, but not limited to, emergency medical services (EMS) personnel.

I understand that this decision will not prevent me from receiving other health care such as the Heimlich maneuver or oxygen and other comfort care measures.

I understand that I may revoke this consent at any time in one of the following ways:

1. If I am under the care of a health care agency, by making an oral, written, or other act of communication to a physician or other health care provider of a health care agency;

2. If I am not under the care of a health care agency, by destroying my do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation;

3. If I am incapacitated and under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by written notification of a physician or other health care provider of the health care agency or by oral notification of my attending physician; or

4. If I am incapacitated and not under the care of a health care agency, my representative may revoke the do-not-resuscitate consent by destroying the do-not-resuscitate form, removing all do-not-resuscitate identification from my person, and notifying my attending physician of the revocation.

I give permission for this information to be given to EMS personnel, doctors, nurses, and other health care providers. I hereby state that I am making an informed decision and agree to a do-not-resuscitate order.

_____ or _____

Signature of Person

Signature of Representative
(Limited to an attorney-in-fact for health care decisions acting under the Durable Power of Attorney Act, a health care proxy acting under the Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act or a guardian of the person appointed under the Oklahoma Guardianship and Conservatorship Act.)

This DNR consent form was signed in my presence.

_____
Date

_____
Signature of Witness

_____
Address

_____
Signature of Witness

_____
Address

For free legal assistance in completing this form, call Richard Ingham, Legal Services Developer, Aging Services Division of DHS, (405) 522-3069.

CERTIFICATION OF PHYSICIAN

This form is to be used by an attending physician only to certify that an incapacitated person without a representative would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. An attending physician of an incapacitated person without a representative must know by clear and convincing evidence that the incapacitated person, when competent, decided on the basis of information sufficient to constitute informed consent that such person would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Clear and convincing evidence for this purpose shall include oral, written, or other acts of communication between the patient, when competent, and family members, health care providers, or others close to the patient with knowledge of the patient's desires.

I hereby certify, based on clear and convincing evidence presented to me, that I believe that _____

Name of Incapacitated Person

would not have consented to the administration of cardiopulmonary resuscitation in the event of cardiac or respiratory arrest. Therefore, in the event of cardiac or respiratory arrest, no chest compressions, artificial ventilation, intubations, defibrillation, or emergency cardiac medications are to be initiated.

_____ _____

Physician's Signature *Physician's Name (PRINT)*

_____

Physician's Address/Phone

_____

Date

This DNR consent form and Certification of Physician is copied from Senate Bill 715. This law is effective November 1, 1997.

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