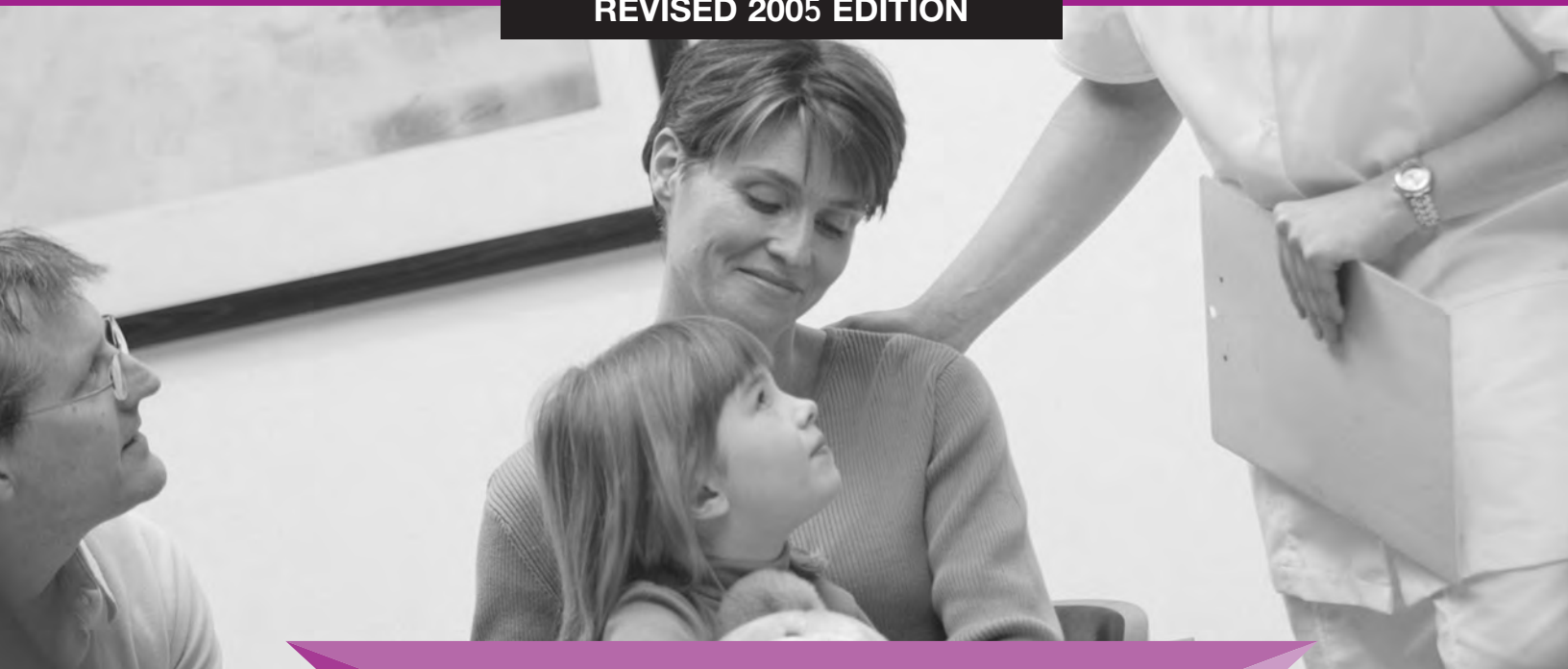


REVISED 2005 EDITION



# A Personal Decision

**Practical information about determining  
your future medical care,  
including living wills,  
powers of attorney for health care,  
mental health treatment preference declarations,  
do not resuscitate decisions,  
and organ donation**

Provided by  
the Illinois State Medical Society

## Illinois Department of Public Health



## STATEMENT OF ILLINOIS LAW ON ADVANCE DIRECTIVES AND DNR ORDERS

*Last Updated June 1, 2005*

**Y**ou have the right to make decisions about the health care you get now and in the future. An advance directive is a written statement you prepare about how you want your medical decisions to be made in the future, if you are no longer able to make them for yourself. A do not resuscitate order (DNR order) is a medical treatment order which says that cardiopulmonary resuscitation (CPR) will not be used if your heart or breathing stops.

Federal law requires that you be told of your right to make an advance directive when you are admitted to a health care facility. Illinois law allows for the following three types of advance directives: (1) health care power of attorney; (2) living will; and (3) mental health treatment preference declaration. In addition, you can ask your physician to work with you to prepare a DNR order. You may choose to discuss with your health-care professional and/or attorney these different types of advance directives as well as a DNR order. After reviewing information regarding advance directives and a DNR order, you may decide to make more than one. For example, you could make a health care power of attorney and a living will.

If you make one or more advance directives and/or a DNR order, tell your health-care professional and provide them with a copy. You may also want to provide a copy to family members, and you should provide a copy to those you appoint to make these decisions for you.

State law provides copies of sample advance directives forms and DNR order forms. In addition, this webpage provides a copy of these forms and a copy of the Illinois Department of Public Health (IDPH) Uniform Do-Not-Resuscitate (DNR) Order Form at [www.idph.state.il.us/public/books/advin.htm](http://www.idph.state.il.us/public/books/advin.htm). ■

**HEALTH CARE POWER OF ATTORNEY**

**T**he **health care power of attorney** lets you choose someone to make health care decisions for you in the future, if you are no longer able to make these decisions for yourself. You are called the “principal” in the power of attorney form and the person you choose to make decisions is called your “agent.” Your agent would make health care decisions for you if you were no longer able to make these decisions for yourself. So long as you are able to make these decisions, you will have the power to do so. You may use a standard health care power of attorney form or write your own. You may give your agent specific directions about the health care you do or do not want.

The agent you choose cannot be your health-care professional or other health care provider. You should have someone who is not your agent witness your signing of the power of attorney.

The power of your agent to make health care decisions on your behalf is broad. Your agent would be required to follow any specific instructions you give regarding care you want

provided or withheld. For example, you can say whether you want all life-sustaining treatments provided in all events; whether and when you want life-sustaining treatment ended; instructions regarding refusal of certain types of treatments on religious or other personal grounds; and instructions regarding anatomical gifts and disposal of remains. Unless you include time limits, the health care power of attorney will continue in effect from the time it is signed until your death. You can cancel your power of attorney at any time, either by telling someone or by canceling it in writing. You can name a backup agent to act if the first one cannot or will not take action. If you want to change your power of attorney, you must do so in writing. ■

**LIVING WILL**

**A living will** tells your doctor whether you want death-delaying procedures used if you have a terminal condition and are unable to state your wishes. A living will, unlike a health care power of attorney, only applies if you have a terminal condition. A terminal condition means an incurable and irreversible condition such that death is imminent and the application of any death delaying procedures serve only to prolong the dying process.

Even if you sign a living will, food and water cannot be withdrawn if it would be the only cause of death. Also, if you are pregnant and doctors think you could have a live birth, your living will cannot go into effect.

You can use a standard living will form or write your own. You may write specific directions about the death-delaying procedures you do or do not want.

Two people must witness your signing of the living will. Your health-care professional cannot be a witness. It is your responsibility to tell your health-care professional if you have a living will if you are able to do so. You can cancel your living will at any time, either by telling someone or by canceling it in writing.

If you have both a health care power of attorney and a living will, the agent you name in your power of attorney will make your health care decisions unless he or she is unavailable. ■

**MENTAL HEALTH TREATMENT PREFERENCE DECLARATION**

**A mental health treatment preference declaration** lets you say if you want to receive electroconvulsive treatment (ECT) or psychotropic medicine when you have a mental illness and are unable to make these decisions for yourself. It also allows you to say whether you wish to be admitted to a mental health facility for up to 17 days of treatment.

You can write your wishes and/or choose someone to make your mental health decisions for you. In the declaration, you are called the “principal” and the person you choose is called an “attorney-in-fact.” Neither your health-care professional nor any employee of a health-care facility you reside in may be your attorney-in-fact. Your attorney-in-fact must accept the appointment in writing before he or she can

start making decisions regarding your mental health treatment. The attorney-in-fact must make decisions consistent with any desires you express in your declaration unless a court orders differently or an emergency threatens your life or health.

Your mental health treatment preference declaration expires three years from the date you sign it. Two people must witness you signing the declaration. The following people may not witness your signing of the declaration: your health-care professional; an employee of a health-care facility in which you reside; or a family member related by blood, marriage, or adoption. You may cancel your declaration in writing prior to its expiration as long as you are not receiving mental health treatment at the time of cancellation. If you are receiving mental health treatment, your declaration will not expire and you may not cancel it until the treatment is successfully completed. ■

### DO-NOT-RESUSCITATE ORDER

**Y**ou may also ask your health-care professional about a **do-not-resuscitate order** (DNR order). A DNR order is a medical treatment order stating that cardiopulmonary resuscitation (CPR) will not be started if your heart and/or breathing stops. The law authorizing the development of the form specifies that an individual (or his or her authorized legal representative) may execute the IDPH Uniform DNR Order Form directing that resuscitation efforts shall not be attempted. Therefore, a DNR order completed on the IDPH Uniform DNR Order Form contains an advance directive made by an individual (or legal representative), and also contains a physician's order that requires a physician's signature. You may sign a document directing that, should your heart or breathing stop, efforts to resuscitate you will not be started. Your attending physician may also sign a DNR order.

Before a DNR order may be entered into your medical record, either you or another person (your legal guardian, health care power of attorney, or surrogate decision-maker) must consent to the DNR order. This consent must be witnessed by two people who are 18 years or older. If a DNR order is entered into your medical record, appropriate medical treatment other than CPR will be given to you. This webpage provides a copy of the Illinois Department of Public Health (IDPH) Uniform Do Not Resuscitate (DNR) Order Form that may be used by you and your physician: [[www.idph.state.il.us/public/books/advin.htm](http://www.idph.state.il.us/public/books/advin.htm)]. This webpage also provides a link to guidance for individuals, health-care professionals and health-care providers concerning the IDPH Uniform DNR Order Form. ■

### WHAT HAPPENS IF YOU DON'T HAVE AN ADVANCE DIRECTIVE?

**U**nder Illinois law, a health care "surrogate" may be chosen for you if you cannot make health care decisions for yourself, and do not have an advance directive. A health care surrogate will be one of the following persons (in order of priority): guardian of the person, spouse, any adult child(ren),

either parent, any adult brother or sister, any adult grandchild(ren), a close friend, or guardian of the estate.

The surrogate can make all health care decisions for you, with certain exceptions. A health care surrogate cannot tell your health-care professional to withdraw or withhold life-sustaining treatment unless you have a "qualifying condition," which is a terminal condition, permanent unconsciousness, or an incurable or irreversible condition. A "terminal condition" is an incurable or irreversible injury for which there is no reasonable prospect of cure or recovery, death is imminent, and life-sustaining treatment will only prolong the dying process. "Permanent unconsciousness" means a condition that, to a high degree of medical certainty, will last permanently, without improvement; there is no thought, purposeful social interaction or sensory awareness present; and providing life-sustaining treatment will only have minimal medical benefit. An "incurable or irreversible condition" means an illness or injury for which there is no reasonable prospect for cure or recovery, that ultimately will cause the patient's death, that imposes severe pain or an inhumane burden on the patient, and for which life-sustaining treatment will have minimal medical benefit.

Two doctors must certify that you cannot make decisions and have a qualifying condition in order to withdraw or withhold life-sustaining treatment. If your health care surrogate decision-maker decides to withdraw or withhold life-sustaining treatment, this decision must be witnessed by a person who is 18 years or older. A health care surrogate may consent to a DNR order; however, this consent must be witnessed by two individuals 18 years or older.

A health care surrogate, other than a court-appointed guardian, cannot consent to certain mental health treatments, including treatment by electroconvulsive therapy (ECT), psychotropic medication, or admission to a mental health facility. A health care surrogate can petition a court to allow these mental health services. ■

### FINAL NOTES

**Y**ou should talk with your family, your health-care professionals, your attorney, and any agent or attorney-in-fact that you appoint about your decision to make one or more advance directives or a DNR order. If they know what health care you want, they will find it easier to follow your wishes. If you cancel or change an advance directive or a DNR order in the future, remember to tell these same people about the change or cancellation.

No facility, health-care professional, or insurer can make you execute an advance directive or DNR order as a condition of providing treatment or insurance. It is entirely your decision. If a facility, health-care professional, or insurer objects to following your advance directive or DNR order, then they must tell you or the individual responsible for making your health care decisions. They must continue to provide care until you or your decision-maker can transfer you to another health care provider who will follow your advance directive or DNR order. ■

## DETERMINING YOUR MEDICAL CARE IS YOUR RIGHT

### YOU CAN DECIDE TODAY ABOUT THE CARE YOU WILL RECEIVE IN THE FUTURE

While advances in medicine and medical technology can save many lives that only fifty years ago might have been lost, the issue of quality at the end of life has come under intensive judicial and public scrutiny. In the state of Illinois, it is your legal right at all times to determine the degree and kind of care you wish to receive. This includes your right to consent to or refuse medical care and treatment as long as you are capable of doing so. You can also decide today and direct your health care providers and family about the care you want in the event of an illness or injury, including terminal illness, if you are unable then to make these decisions. You can decide today if you want procedures such as artificial breathing and kidney treatments, feeding through a tube or a vein, among others, if they would only prolong the process of dying and do no more than delay your death.

Decisions about the quality of the end of life – about life support systems, aggressive resuscitation efforts, about hydration and nutrition of comatose patients – are all serious, personal decisions each of us must arrive at privately. Neither the law nor any person can require you to make such a decision against your will. If you wish to exercise your right to determine the care you receive should you be injured or ill, this brochure will help you make an informed decision ■

### HOW TO INDICATE YOUR DECISIONS

In Illinois three documents are available for your use in directing your health care when you are incapable of doing so: the durable power of attorney for health care, mental health treatment preference declaration, and the living will. You can use any one or more of these documents or you may write out your wishes and directives. The choice is yours, and you can change your mind at any time except for the declaration under specified circumstances. ■

### DURABLE POWER OF ATTORNEY FOR HEALTH CARE

In the state of Illinois the best way to assure that your instructions about your health care are followed is through the use of a **durable power of attorney for health care**.

Using this document you can designate someone else, called an agent, to make decisions about your health care in the event you are unable to do so yourself. This person can, by law, be anyone you choose over the age of 18, except the doctor providing your care. This person will have the legal right and responsibility to make decisions about your health care, including the initiation and termination of medical procedures and life support systems, organ donation and autopsy.

For example, a person with irreversible brain injuries remains in a coma from which doctors have determined the patient will never recover. The agent designated in the durable



power of attorney for health care can refuse the antibiotic treatment that the hospital would administer should the patient develop pneumonia. Without antibiotics, the pneumonia would most likely be fatal. Because the patient has determined — in advance, through discussion with their agent and by signing the durable power of attorney — that death should not be delayed in this circumstance, the agent is authorized to decline lifesaving efforts.

Most people select a member of their family or a close friend to act as their agent in these situations. You may designate several agents, in case your first choice of a decision-maker is unavailable or unwilling to serve. Whomever you choose, you should discuss your wishes with them.

While your caregivers must respect your agent's decisions and the court will uphold them, the agent can be removed by the court if doing so is determined to be in your best interest. Your physician and the hospital will also play a part in that decision.

This booklet includes a short form Durable Power of Attorney for Health Care, legal in the state of Illinois. This form is not required, but it is the surest way to meet all the specifications of Illinois law. If you decide to execute the durable power of attorney, be sure to inform your doctor, the hospital and your family. Keep the form in a safe place and let someone you trust know where it is. ■

### DECLARATION FOR MENTAL HEALTH TREATMENT

For persons with views limited to mental health care, the state of Illinois has a unique document specifically limited to three types of mental health treatment known as the Declaration For Mental Health Treatment.

Using this document you can designate someone else, called an attorney-in-fact, to make decisions about your mental health care in the event you are unable to do so yourself. This person can, by law, be anyone you choose over the age of 18, except your attending physician and persons involved or related to the physician or your health care facility. This person will have the legal right and responsibility to make limited decisions about your mental health care concerning: (1) electroconvulsive treatment, (2) psychotropic medication, and (3) admission for up to 17 days in a mental health facility.

Most people select a member of their family or a close friend to act as their attorney-in-fact in these situations. Whomever you choose, you should discuss your wishes with them.

This booklet includes the statutory Declaration For Mental Health Treatment form legal in the state of Illinois. This form is not required, but it is the surest way to meet all the specifications of Illinois law. If you decide to execute a Declaration or Mental Health Treatment, be sure to inform your doctor, mental health care professional and your family. Keep the form in a safe place and let someone you trust know where it is. ■

### THE LIVING WILL

The living will does not appoint another person to make your health care decisions but declares your intent that if your medical condition is incurable and irreversible, the people taking care of you not delay your death, if it is imminent, through lifesaving measures. It allows you to control your health care even if you cannot communicate with the people caring for you.

For example, a cancer patient whom the doctors estimate has only weeks to live can, through the use of a living will, instruct the hospital that no extraordinary measures are to be taken to prolong her life; if she suffers cardiac arrest, for example, the hospital is not to attempt to revive her. She may also choose to decline the future use of a respirator or techniques such as blood transfusions or kidney dialysis.

Any adult (over the age of 18) of sound mind can make a living will. It must be created as a voluntary act, must be signed by a patient (or another person at the direction of the patient) and must be witnessed by two adults. The living will has no effect legally unless the physician responsible for the patient's care certifies, in writing, that the patient's condition is terminal, that death is imminent, and that death-delaying procedures will only prolong the process of dying. Nutrition and hydration may not be withheld or withdrawn if such act and not the existing medical condition will cause death. The living will form in this brochure has been developed by the Illinois legislature; you may include other directions and instructions, as well. ■

### UNIFORM DO-NOT-RESUSCITATE (DNR) ORDER FORM

The Do-Not-Resuscitate (DNR) Order, similar to the Living Will, does not appoint another person to make your health care decisions, but declares your intent that if you cannot make decisions yourself, you do not want cardiopulmonary resuscitation to be performed when both your heartbeat and breathing stop.

Any adult (over the age of 18) of sound mind can prepare a Uniform Do-Not-Resuscitate (DNR) Order Form. It must be created as a voluntary act, must be signed by a patient (or another person at the direction of the patient or a surrogate decision-maker), the patient's attending physician and witnessed by two adults. The Uniform Do-Not-Resuscitate (DNR) Order Form in this brochure has been developed by the Illinois Department of Public Health. [Please note physicians may also execute physician DNR orders without the use of this form]. ■

### CHANGING YOUR DECISION

You can at any time amend, alter or void your living will or durable power of attorney by destroying the document or preparing a written statement declaring your intent to set them aside. A Declaration For Mental Health Treatment may only be amended or revoked by competent persons in writing and signed by the principal and physician. Incompetent patients may not amend or revoke a Declaration.

The forms in this brochure allow you to direct your family, your health care professionals and the others involved in your medical care to follow your wishes, should the time come when these difficult decisions must be made. You need not consult an attorney to put any of these into effect; it is very important, however, that you discuss your decisions and these documents with your family, your physician and your legal advisor, to assure that your wishes are followed. ■

### CONSEQUENCES OF NOT EXECUTING AN ADVANCE DIRECTIVE

If you do not execute an advance directive and you lack decisional capacity, a surrogate may be appointed for you. This surrogate will have the authority to make medical treatment decisions for you. If your medical condition is terminal, incurable or irreversible, or you are permanently unconscious, your surrogate may also make life-sustaining treatment decisions for you. A surrogate, other than a court appointed guardian, may not consent to administration of electroconvulsive therapy or psychotropic medication or admission to a mental health facility without court approval. In other circumstances, your hospital, another health care institution or doctors may be required to do everything in their power to keep you alive, no matter what your condition or chances of recovery. ■



## Living Will

The Living Will Act includes the following suggested form:

Declaration (as included in the Illinois Living Will Act, 755 ILCS 35/3)

This declaration is made this \_\_\_\_\_ day of \_\_\_\_\_  
\_\_\_\_\_  
(month, year).

I, \_\_\_\_\_, 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 or other instrument taking effect at declarant's death or directly financially responsible for declarant's medical care.

Witness \_\_\_\_\_

Witness \_\_\_\_\_

**(Comment:** *Even though the Act states that another form may be used, which may include specific prohibitions or types of procedures that may be acceptable, it is advisable that any variation from the form above should be subject to review by an attorney to assure its validity.*)

**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE**

*(Notice: the purpose of this power of attorney is to give the person you designate (your “agent”) broad powers to make health care decisions for you, including power to require, consent to or withdraw any type of personal care or medical treatment for any physical or mental condition and to admit you to or discharge you from any hospital, home or other institution. This form does not impose a duty on your agent to exercise granted powers; but when powers are exercised, your agent will have to use due care to act for your benefit and in accordance with this form and keep a record of receipts, disbursements and significant actions taken as agent. A court can take away the powers of your agent if it finds the agent is not acting properly. You may name successor agents under this form but not co-agents, and no health care provider may be named. Unless you expressly limit the duration of this power in the manner provided below, until you revoke this power or a court acting on your behalf terminates it, your agent may exercise the powers given here throughout your lifetime, even after you become disabled. The powers you give your agent, your right to revoke those powers and the penalties for violating the law are explained more fully in sections 4-5, 4-6, 4-9 and 4-10(b) of the Illinois “Powers of Attorney for Health Care Law,” of which this form is a part. That law expressly permits the use of any different form of power of attorney you may desire. If there is anything about this form that you do not understand, you should ask a lawyer to explain it to you.)*

**Power of Attorney** made this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_.

(month) (year)

**1. I,** \_\_\_\_\_  
(insert name and address of principal)

hereby appoint \_\_\_\_\_  
(insert name and address of agent)

as my attorney-in-fact (my “agent”) to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, even though my death may ensue. My agent shall have the same access to my medical records that I have, including the right to disclose the contents to others. My agent shall also have full power to authorize an autopsy and direct the disposition of my remains. Effective upon my death, my agent has the full power to make an anatomical gift of the following (initial one):

\_\_\_\_\_ Any organs, tissues or eyes suitable for transplantation or used for research or education.

\_\_\_\_\_ Specific organs: \_\_\_\_\_

*(The above grant of power is intended to be as broad as possible so that your agent will have authority to make any decision you could make to obtain or terminate any type of health care, including withdrawal of food and water and other life-sustaining measures, if your agent believes such action would be consistent with your intent and desires. If you wish to limit the scope of your agent’s powers or prescribe special rules or limit the power to make an anatomical gift, authorize autopsy or dispose of remains, you may do so in the following paragraphs.)*

**2.** The powers granted above shall not include the following powers or shall be subject to the following rules or limitations (here you may include any specific limitations you deem appropriate, such as: your own definition of when life-sustaining measures should be withheld; a direction to continue food and fluids or life-sustaining treatment in all events; or instructions to refuse any specific types of treatment that are inconsistent with your religious beliefs or unacceptable to you for any other reason, such as blood transfusion, electroconvulsive therapy, amputation, psychosurgery, voluntary admission to a mental institution, etc.): \_\_\_\_\_

*(The subject of life-sustaining treatment is of particular importance. For your convenience in dealing with that subject, some general statements concerning the withholding or removal of life-sustaining treatment are set forth below. If you agree with one of these statements, you may initial that statement; but do not initial more than one):*

I do not want my life to be prolonged nor do I want life-sustaining treatment to be provided or continued if my agent believes the burdens of the treatment outweigh the expected benefits. I want my agent to consider the relief of suffering, the expense involved and the quality as well as the possible extension of my life in making decisions concerning life-sustaining treatment. \_\_\_\_\_  
initialed

I want my life to be prolonged and I want life-sustaining treatment to be provided or continued unless I am in a coma which my attending physician believes to be irreversible, in accordance with reasonable medical standards at the time of reference. If and when I have suffered irreversible coma, I want life-sustaining treatment to be withheld or discontinued. \_\_\_\_\_  
initialed

I want my life to be prolonged to the greatest extent possible without regard to my condition, the chances I have for recovery or the cost of the procedures. \_\_\_\_\_  
initialed

**ILLINOIS STATUTORY SHORT FORM POWER OF ATTORNEY FOR HEALTH CARE (CONTINUED)**

*(This power of attorney may be amended or revoked by you in the manner provided in section 4-6 of the Illinois "Powers of Attorney for Health Care Law." Absent amendment or revocation, the authority granted in this power of attorney will become effective at the time this power is signed and will continue until your death, and beyond if anatomical gift, autopsy or disposition of remains is authorized, unless a limitation on the beginning date or duration is made by initialing and completing either or both of the following:)*

**3.** (      ) This power of attorney shall become effective on \_\_\_\_\_

(insert a future date or event during your lifetime, such as a court determination of your disability, when you want this power to first take effect).

**4.** (      ) This power of attorney shall terminate on \_\_\_\_\_

(insert a future date or event, such as a court determination of your disability, when you want this power to terminate prior to your death).

*(If you wish to name successor agents, insert the names and addresses of such successors in the following paragraph.)*

**5.** If any agent named by me shall die, become incompetent, resign, refuse to accept the office of agent or be unavailable, I name the following (each to act alone and successively, in the order named) as successors to such agent:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For purposes of this paragraph 5, a person shall be considered to be incompetent if and while the person is a minor or an adjudicated incompetent or disabled person or the person is unable to give prompt and intelligent consideration to health care matters, as certified by a licensed physician.

*(If you wish to name your agent as guardian of your person, in the event a court decides that one should be appointed, you may, but are not required to, do so by retaining the following paragraph. The court will appoint your agent if the court finds that such appointment will serve your best interests and welfare. Strike out paragraph 6 if you do not want your agent to act as guardian.)*

**6.** If a guardian of my person is to be appointed, I nominate the agent acting under this power of attorney as such guardian, to serve without bond or security.

**7.** I am fully informed as to all the contents of this form and understand the full import of this grant of powers to my agent.

Signed \_\_\_\_\_  
(principal)

The principal has had an opportunity to read the above form and has signed the form or acknowledged his or her signature or mark on the form in my presence.

\_\_\_\_\_ Residing at: \_\_\_\_\_  
(witness)

(You may, but are not required to, request your agent and successor agents to provide specimen signatures below. If you include specimen signatures in this power of attorney, you must complete the certification opposite the signatures of the agents.)

Specimen signatures of agent (and successors).

I certify that the signatures of my agent (and successors) are correct.

\_\_\_\_\_  
(agent)

\_\_\_\_\_  
(principal)

\_\_\_\_\_  
(successor agent)

\_\_\_\_\_  
(principal)

\_\_\_\_\_  
(successor agent)

\_\_\_\_\_  
(principal)

**DECLARATION FOR MENTAL HEALTH TREATMENT**

I, \_\_\_\_\_, being an adult of sound mind, willfully and voluntarily make this declaration for mental health treatment to be followed if it is determined by two physicians or the court that my ability to receive and evaluate information effectively or communicate decisions is impaired to such an extent that I lack the capacity to refuse or consent to mental health treatment. “Mental health treatment” means electroconvulsive treatment, treatment of mental illness with psychotropic medication, and admission to and retention in a health care facility for a period up to 17 days.

I understand that I may become incapable of giving or withholding informed consent for mental health treatment due to the symptoms of a diagnosed mental disorder. These symptoms may include:

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**PSYCHOTROPIC MEDICATIONS**

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding psychotropic medications are as follows:

\_\_\_\_\_ I consent to the administration of the following medications: \_\_\_\_\_

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\_\_\_\_\_ I do not consent to the administration of the following medications: \_\_\_\_\_

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Conditions or limitations:

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**ELECTROCONVULSIVE TREATMENT**

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding electroconvulsive treatment are as follows:

\_\_\_\_\_ I consent to the administration of electroconvulsive treatment.

\_\_\_\_\_ I do not consent to the administration of electroconvulsive treatment.

Conditions or limitations:

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**ADMISSION TO AND RETENTION IN FACILITY**

If I become incapable of giving or withholding informed consent for mental health treatment, my wishes regarding admission to and retention in a health care facility for mental health treatment are as follows:

\_\_\_\_\_ I consent to being admitted to a health care facility for mental health treatment.

\_\_\_\_\_ I do not consent to being admitted to a health care facility for mental health treatment. This directive cannot, by law, provide consent to retain me in a facility for more than 17 days.

Conditions or limitations:

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**SELECTION OF PHYSICIAN** *(optional)*

If it becomes necessary to determine if I have become incapable of giving or withholding informed consent for mental health treatment, I choose Dr. \_\_\_\_\_ of \_\_\_\_\_ to be one of the 2 physicians who will determine whether I am incapable. If that physician is unavailable, that physician’s designee shall determine whether I am incapable.

Illinois Official Statutory Declaration for Mental Health Treatment Form, side two

**ADDITIONAL REFERENCES OR INSTRUCTIONS**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Conditions or limitations: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**ATTORNEY-IN-FACT**

I hereby appoint:

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**TELEPHONE #:** \_\_\_\_\_

to act as my attorney-in-fact to make decisions regarding my mental health treatment if I become incapable of giving or withholding informed consent for that treatment.

If the person named above refuses or is unable to act on my behalf, or if I revoke that person's authority to act as my attorney-in-fact, I authorize the following person to act as my attorney-in-fact:

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**TELEPHONE #:** \_\_\_\_\_

My attorney-in-fact is authorized to make decisions that are consistent with the wishes I have expressed in this declaration or, if not expressed, as are otherwise known to my attorney-in-fact. If my wishes are not expressed and are not otherwise known by my attorney-in-fact, my attorney-in-fact is to act in what he or she believes to be my best interest.

\_\_\_\_\_  
(Signature of Principal/Date)

**AFFIRMATION OF WITNESSES**

We affirm that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this declaration for mental health treatment in our presence, that the principal appears to be of sound mind and not under duress, fraud or undue influence, that neither of us is:

- A person appointed as an attorney-in-fact by this document;
  - The principal's attending physician or mental health service provider or a relative of the physician or provider;
  - The owner, operator, or relative of an owner or operator of a facility in which the principal is a patient or resident;
- or
- A person related to the principal by blood, marriage or adoption.

*Witnessed By:*

\_\_\_\_\_  
(Signature of Witness/Date)

\_\_\_\_\_  
(Printed Name of Witness)

\_\_\_\_\_  
(Signature of Witness/Date)

\_\_\_\_\_  
(Printed Name of Witness)

**ACCEPTANCE OF APPOINTMENT AS ATTORNEY-IN-FACT**

I accept this appointment and agree to serve as attorney-in-fact to make decisions about mental health treatment for the principal. I understand that I have a duty to act consistent with the desires of the principal as expressed in this appointment. I understand that this document gives me authority to make decisions about mental health treatment only while the principal is incapable as determined by a court or two physicians. I understand that the principal may revoke this declaration in whole or in part at any time and in any manner when the principal is not incapable.

\_\_\_\_\_  
(Signature of Attorney-in-Fact/Date)

\_\_\_\_\_  
(Printed Name)

\_\_\_\_\_  
(Signature of Attorney-in-Fact/Date)

\_\_\_\_\_  
(Printed Name)

**NOTICE TO PERSON MAKING A DECLARATION FOR MENTAL HEALTH TREATMENT**

This is an important legal document. It creates a declaration for mental health treatment. Before signing this document, you should know these important facts:

This document allows you to make decisions in advance about three types of mental health treatment: psychotropic medication, electroconvulsive therapy, and short-term (up to 17 days) admission to a treatment facility. The instructions that you include in this declaration will be followed only if two physicians or the court believes that you are incapable of making treatment decisions. Otherwise, you will be considered capable to give or withhold consent for the treatments.

You may also appoint a person as your attorney-in-fact to make these treatment decisions for you if you become incapable. The person you appoint has a duty to act consistent with your desires as stated in this document or, if your desires are not stated or otherwise made known to the attorney-in-fact, to act in a manner consistent with what the person in good faith believes to be in your best interest. For the appointment to be effective, the person you appoint must accept the appointment in writing. The person also has the right to withdraw from acting as your attorney-in-fact at any time.

This document will continue in effect for a period of three years unless you become incapable of participating in mental health treatment decisions. If this occurs, the directive will continue in effect until you are no longer incapable.

You have the right to revoke this document in whole or in part at any time you have been determined by a physician to be capable of giving or withholding informed consent for mental health treatment. A revocation is effective when it is communicated to your attending physician in writing and is signed by you and a physician. The revocation may be in a form similar to the following:

**REVOCAION**

I, \_\_\_\_\_, willfully and voluntarily revoke my declaration for mental health treatment as indicated.

I revoke my entire declaration.

I revoke the following portion of my declaration:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
(Signature of principal)

I, Dr. \_\_\_\_\_, have evaluated the principal and determined that he or she is capable of giving or withholding informed consent for mental health treatment.

Date: \_\_\_\_\_

Signed: \_\_\_\_\_  
(Signature of physician)

If there is anything in this document that you do not understand, you should ask a lawyer to explain it to you. This declaration will not be valid unless it is signed by two qualified witnesses who are personally known to you and who are present when you sign or acknowledge your signature.



Illinois Department of Public Health  
**UNIFORM DO-NOT-RESUSCITATE (DNR) ORDER FORM**

**Patient Directive**

I, \_\_\_\_\_, born on \_\_\_\_\_, hereby direct the following in the event of:  
(print full name) (birth date)

**1. FULL CARDIOPULMONARY ARREST (When both breathing and heartbeat stop):**

**Do Not Attempt Cardiopulmonary Resuscitation (CPR)**  
(Measures to promote patient comfort and dignity will be provided.)

**2. PRE-ARREST EMERGENCY (When breathing is labored or stopped, and heart is still beating):**

**SELECT ONE**

- Do Attempt Cardiopulmonary Resuscitation (CPR) -OR-**
- Do Not Attempt Cardiopulmonary Resuscitation (CPR)**  
(Measures to promote patient comfort and dignity will be provided.)

**Other Instructions** \_\_\_\_\_  
\_\_\_\_\_

**Patient Directive Authorization and Consent to DNR Order** (Required to be a valid DNR Order)

I understand and authorize the above Patient Directive, and consent to a physician DNR Order implementing this Patient Directive.

\_\_\_\_\_  
Printed name of individual                      Signature of individual                      Date

-OR-

\_\_\_\_\_  
Printed name of (circle appropriate title):                      Signature of legal representative                      Date  
legal guardian  
OR agent under health care power of attorney  
OR healthcare surrogate decision maker

**Witness to Consent** (Required to have two witnesses to be a valid DNR Order)

I am 18 years of age or older and have witnessed the giving of consent by the above person.

\_\_\_\_\_  
Printed name of witness                      Signature of witness                      Date

\_\_\_\_\_  
Printed name of witness                      Signature of witness                      Date

**Physician Signature** (Required to be a valid DNR Order)

I hereby execute this DNR Order on \_\_\_\_\_.  
Today's date

\_\_\_\_\_  
Signature of attending physician                      Printed Name of attending physician                      Physician's telephone number

◆ *Send this form or a copy of both sides with the individual upon transfer or discharge.* ◆



Illinois Department of Public Health  
**UNIFORM DO-NOT-RESUSCITATE (DNR) ORDER FORM**

Patient's name \_\_\_\_\_

**Summarize medical condition:**

**When This Form Should Be Reviewed**

This DNR order, in effect until revoked, should be reviewed periodically, particularly if –

- The patient/resident is transferred from one care setting or care level to another, or
- There is a substantial change in patient/resident health status, or
- The patient/resident treatment preferences change.

**How to Complete the Form Review**

1. Review the other side of this form.
2. Complete the following section.  
 If this form is to be voided, write "VOID" in large letters on the other side of the form.  
 After voiding the form, a new form may be completed.

<u>Date</u>	<u>Reviewer</u>	<u>Location of review</u>	<b><u>Outcome of Review</u></b>
			<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED; new form completed <input type="checkbox"/> FORM VOIDED; <b>no</b> new form completed

<u>Date</u>	<u>Reviewer</u>	<u>Location of review</u>	<b><u>Outcome of Review</u></b>
			<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED; new form completed <input type="checkbox"/> FORM VOIDED; <b>no</b> new form completed

<u>Date</u>	<u>Reviewer</u>	<u>Location of review</u>	<b><u>Outcome of Review</u></b>
			<input type="checkbox"/> No change <input type="checkbox"/> FORM VOIDED; new form completed <input type="checkbox"/> FORM VOIDED; <b>no</b> new form completed

**Advance Directives**

I also have the following advance directives: **Contact person** (name and phone number)

- Health Care Power of Attorney \_\_\_\_\_
- Living Will \_\_\_\_\_
- Mental Health Treatment Preference Declaration \_\_\_\_\_

◆ Send this form or a copy of both sides with the individual upon transfer or discharge. ◆

# ORGAN DONATION

## *Our Final and Best Gift*

Advances in medical technology over the past thirty years have allowed physicians to save lives, restore health and bring the gift of vision through the gift of organ donation.

Organ donation will occur only after everything has been done to save the donor's life and after death has been declared; the procedure is surgical, professional and dignified, and does not interfere with traditional funeral and burial customs. There is no cost to the family of the donor for these procedures.

Advance directives regarding organ donation can be made in a will, in a power of attorney for health care, through an organ donation card, or driver's license notation or by means of other written documents signed by the donor in the presence of two adult witnesses, who must also sign.

You may, at any time, change your mind about your decision by revoking or amending your will or other document or by writing "VOID" across the organ donation card.

Such a card is included in this brochure; in Illinois, you can also sign the reverse side of your driver's license to indicate your willingness to be an organ donor.

Because families are typically consulted before organ donation takes place, you should discuss your decision with your family and physician. ■



## ORGAN DONATION *Our Final and Best Gift*

### ORGAN DONOR CARD

I, \_\_\_\_\_, hereby make the following anatomical gift, if medically acceptable, to take effect upon my death.

ANY ORGANS OR PARTS     ENTIRE BODY

Only the following specific organs or parts:

\_\_\_\_\_

Limitations or special wishes, if any:

\_\_\_\_\_

(Signatures of donor and witnesses appear on reverse side.)

### POWER OF ATTORNEY FOR HEALTH CARE OR DECLARATION FOR MENTAL HEALTH TREATMENT

#### *Notification Card*

I, \_\_\_\_\_, have signed a Power of Attorney for Health Care or declaration for mental health treatment, authorizing my named agent to make all my health care decisions for me if I am unable to do so.

Agent name: \_\_\_\_\_

Day phone: \_\_\_\_\_ Eve. phone: \_\_\_\_\_

Successor agent name: \_\_\_\_\_

Day phone: \_\_\_\_\_ Eve. phone: \_\_\_\_\_

### Organ Donor Card *(side two)*

Signed by the donor and the following two witnesses in the presence of each other.

Donor Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date Signed: \_\_\_\_\_

City and State: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

This is a legal document under the Uniform Anatomical Gift Act or similar laws.

### LIVING WILL or DO-NOT-RESUSCITATE ORDER FORM

#### *Notification Card*

I, \_\_\_\_\_, have signed a living will or a do-not-resuscitate order form. If my condition is terminal, a copy may be obtained from:

Name: \_\_\_\_\_

Day phone: \_\_\_\_\_

Eve. phone: \_\_\_\_\_

If I am not for me,  
who will be?

And if not now,  
when?

For additional copies, contact:



**Illinois State Medical Society**

Twenty North Michigan Avenue

Suite 700

Chicago, Illinois 60602

312-782-1654

800-782-4767

**[www.isms.org](http://www.isms.org)**

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