BOSTON MOUNTAIN RURAL HEALTH CENTER, INC
CLINICAL POLICY AND PROCEDURE MANUAL
HEALTH CARE DECLARATIONS
IN ARKANSAS

OVERVIEW

Under Arkansas Law*, if you are a competent adult age 18 or older, you have the right to participate in making your own medical treatment decisions, including the right to accept or refuse specific forms of health care. As one means of exercising this right, the law allows you to complete written declarations containing instructions as to the kinds of health care decisions you wish to have made on your behalf if you become terminally ill or permanently unconscious and unable to make such decisions on your own. These declarations serve much the same purpose under the Arkansas law as "living wills" serve in other states.

SUGGESTED FORMS OF DECLARATION

Arkansas law specifies two standard forms of declaration, one dealing with the possibility of terminal illness, the other dealing with the possibility of permanent unconsciousness. If you wish to make a declaration, you are free to use either or both of these suggested forms, and you are also free to use different wording. You may obtain the standard forms or information on where to obtain them from your physician or other health care provider or from your attorney.

You should be aware that the standard forms do not necessarily address all of the choices you may have the legal right to make. For example, you may wish to insert more detailed instructions concerning your care, such as whether you do or do not wish to have water and food given to you through artificial means if you become terminally ill or permanently unconscious. If you have the standard forms by adding the special instructions, you may wish to consult with a lawyer or other qualified professional.

CHOICES CONTAINED IN THE STANDARD FORMS OF DECLARATION

Each of the standard forms of declaration allows you to choose one of the following approaches:

1. To instruct your physician to withhold or withdraw life-sustaining treatments that are no longer necessary for your comfort, care, or the alleviation of pain; or
2. To appoint someone else to act as your health care proxy (representative) in making health decisions, including the decision to withhold or withdraw life sustaining treatment if you become terminally ill or permanently unconscious.

STEPS FOR COMPLETING A DECLARATION

To be effective, your declaration(s) must be signed by you or by someone else acting at your direction and must be witnessed by two individuals. A declaration becomes effective when both of the following have occurred:

1. The declaration is communicated to your attending physician (the physician primarily responsible for your care) ; and
2. Your attending physician and another consulting physician together determine that you are in terminal condition and no longer able to make decisions regarding administration of life-sustaining treatment.

IF YOU WISH TO REVOKE YOU DECLARATION(s)

If you have completed a health care declaration and later wish to revoke it, you may do so at any time and in any manner, without regard to your mental or physical condition at the time you wish to revoke. A revocation becomes effective when it is communicated to the attending physician or other health care provider by the person who is revoking, or by someone who is a witness to the revocation. Methods of revocation include, for example, a clear written or oral expression of your wish to revoke or physical destruction of the original and any copies of the declaration.

COMPLETING A HEALTH CARE DECLARATION FOR ANOTHER PERSON

In the case of minors and adults who are no longer able to make health care decisions, a declaration may be executed by another person acting on their behalf. Arkansas law establishes the following order of priority and provides that a declaration may be executed by the first of the following individuals, or category of individuals, who exists and is reasonably available for consultation:

1. A legal guardian of the patient, if one has been appointed;
2. The parents of the patient, the case of an unmarried patient under age 18;
3. The patient's spouse;
4. The patient's adult child (or, if there is more than one, the majority of the patient's adult children participating in the decision);
5. The parents of a patient over the age 18;
6. The patient's adult sibling (or, if there is more than one, the majority of them participating in the decision);
7. Persons standing "in loco parentis" (In place of the parents) to the patients;
8. A majority of the patient's adult heirs at law who participate in the decision.

SAFEGUARDS

In addition, Arkansas law affords the following protections:

1. A patient, even one who has been determined to be terminally ill, may continue to make decisions regarding life-sustaining treatment so long as he or she is able to do so;
2. The declaration of a terminally ill patient will not be given effect in the case of a woman known to be pregnant, as long as it is possible that the fetus could develop to the point of live birth with continued application of life-sustaining treatment;
3. Any physical or other health care provider who is unwilling to carry out the instructions of a patient or health care proxy under the law has an obligation to take all reasonable steps necessary to transfer the care of such patient to another physician or health care provider who will do so;
4. In Arkansas, it is improper for a health care provider or insurer to either prohibit or require the execution of a declaration as a condition of receiving health insurance coverage or the delivery of health care services.
5. A declaration executed in another stated in compliance with the law of that state is also valid for the purposes of Arkansas law.

A.C.A. 20-17-201, et seq. Other Rights of minors are covered in A.C.A. 20-17-214.

BOSTON MOUNTAIN RURAL HEALTH CENTER, INC.

Living Will Declaration

/ /

Name of Patient Signing Document Social Security # Date of Birth

If I am permanently unconscious or terminally ill, and am not able to make decisions concerning my medical treatment, I direct my physician to withhold treatment that prolongs the process of my dying and is not necessary to my comfort.

Please put your initials by each procedure that you do NOT want:

_____ Cardiac Resuscitation (CPR)
_____ Surgery
_____ Artificially Administered Feeding & Fluids (Feeding Tubes)
_____ Antibiotics (Infection Fighting Drugs)
_____ Kidney Dialysis
_____ Respirator/Ventilator
_____ Blood Products
_____ Other: _____

This Document is intended to be a LIVING WILL in accordance with the Arkansas Right or the .

Signature: _____Date____/____/_____

_____ / / _____ / /

Witness Signature Date Witness Signature Date

HEALTHCARE PROXY

Any time I am permanently or temporarily unable to make healthcare decisions, my HEALTHCARE PROXY will be:

My Healthcare Proxy may make all decisions about:

- My Personal Care
- My Medical Care

- Hospitalization
- Whether I shall receive medical treatment or procedures, including artificial feeding and fluids, even though I may die as a result of this decision.

Such decisions will be consistent with my wishes or if my wishes are unknown, will be consistent with my best interest. This document is intended to be durable (Healthcare) power of attorney and declaration and proxy.

Signature: _____ Date ___/___/_____

Witness: _____ Dated ___/___/_____

Witness: _____ Dated ___/___/_____

DECLARATION

For Residents of ARKANSAS

(In the Event of a Terminal Condition)

If I should have an incurable or irreversible condition that will cause my death within a relatively short time, and I am no longer able to make decisions regarding my medical treatment, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill of Permanently Unconscious Act, to:

(CHECK ONE BOX)

☐ 1. Withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain;

☐ 2. Follow the instructions of _____

(Name)

_____

(Address) (Phone)

whom I appoint as my health care proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

Signed this _____ day of _____, _____

Signature _____

Address _____

The declarant voluntarily signed this writing in my presence.

Witness _____ Witness _____

Address _____ Address _____

DECLARATION

(In the Event of Permanent Unconsciousness)

If I should become permanently unconscious, I direct my attending physician, pursuant to the Arkansas Rights of the Terminally Ill or Permanently Unconscious Act to:

☐ 1. Withhold or withdraw treatment that only prolongs the process of dying and is not necessary to my comfort or to alleviate pain;

☐ 2. Follow the instructions of _____

(Name)

_____

(Address) (Phone)

whom I appoint as my health care proxy to decide whether life-sustaining treatment should be withheld or withdrawn.

Signed this _____ day of _____ ,_____
Signature_____
Address_____

The declarant voluntarily signed this writing in my presence.
Witness _____ Witness_____
Address _____ Address_____

Source: ARC 20-17-202

STATE OF ARKANSAS
EMERGENCY MEDICAL SERVICES
DO NOT RESUSCITATE ORDER

Patient's Full Name: _____

_____ _____
Signature of Patient or Health Care Proxy or Legal Guardian Date

ATTENDING PHYSICIAN'S ORDER

I, the undersigned, state that I am the physician for the patient named above.

I hereby direct any and all qualified Emergency Medical Services personnel, commencing on the effective date noted below, to withhold cardiopulmonary resuscitation (cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, and related procedures) from the patient in the event of the patient's cardiac or respiratory arrest. I further direct such personnel to provide the patient other medical interventions such as intravenous fluids, oxygen, or other therapies deemed necessary to provide comfort care or alleviate pain.

_____ _____
Signature of Attending Physician Physician's Telephone number (emergency #)

_____ _____
Physician's Printed/Typed Name Date Order Written