COLORADO
Advance Directive
Planning for Important Health Care Decisions

CaringInfo
1731 King St., Suite 100 Alexandria, VA 22314
www.caringinfo.org
800/658-8898

CaringInfo, a program of the National Hospice and Palliative Care Organization (NHPCO), is a national consumer engagement initiative to improve care at the end of life.

It's About How You LIVE

It's About How You LIVE is a national community engagement campaign encouraging individuals to make informed decisions about end-of-life care and services. The campaign encourages people to:

Learn about options for end-of-life services and care
Implement plans to ensure wishes are honored
Voice decisions to family, friends and health care providers
Engage in personal or community efforts to improve end-of-life care

Note: The following is not a substitute for legal advice. While CaringInfo updates the following information and form to keep them up-to-date, changes in the underlying law can affect how the form will operate in the event you lose the ability to make decisions for yourself. If you have any questions about how the form will help ensure your wishes are carried out, or if your wishes do not seem to fit with the form, you may wish to talk to your health care provider or an attorney with experience in drafting advance directives.

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Using these Materials

BEFORE YOU BEGIN

1. Check to be sure that you have the materials for each state in which you may receive health care.

2. These materials include:
   - Instructions for preparing your advance directive, please read all the instructions.
   - Your state-specific advance directive forms, which are the pages with the gray instruction bar on the left side.

ACTION STEPS

1. You may want to photocopy or print a second set of these forms before you start so you will have a clean copy if you need to start over.

2. When you begin to fill out the forms, refer to the gray instruction bars — they will guide you through the process.

3. Talk with your family, friends, and physicians about your advance directive. Be sure the person you appoint to make decisions on your behalf understands your wishes.

4. Once the form is completed and signed, photocopy the form and give it to the person you have appointed to make decisions on your behalf, your family, friends, health care providers and/or faith leaders so that the form is available in the event of an emergency.

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.

Introduction to Your Colorado Advance Medical Directive

This packet contains a legal document that protects your right to refuse medical treatment you do not want, or to request treatment you do want, in the event you lose the ability to make decisions yourself. You may complete Part One, Part Two, or both, depending on your advance planning needs.

Part One. The **Colorado Medical Durable Power of Attorney** lets you name someone, called an agent, to make decisions about your medical care including decisions about life support if you can no longer speak for yourself. The Medical Durable Power of Attorney is especially useful because it appoints an agent to speak for you any time you are unable to make your own medical decisions, not only at the end of life.

Part Two. The **Colorado Declaration** is your state's living will. It lets you state your wishes about medical care in the event that you develop a terminal condition or are in a persistent vegetative state. Your declaration becomes effective when your doctor and one other doctor certify that you have one of these conditions and you lack the decisional capacity to accept or reject medical or surgical treatment. Decisional capacity means the ability to provide informed consent to or refusal of medical treatment or the ability to make an informed health care benefit decision.

Part Three contains the signature and witness provisions so that your document will be effective.

Following your, *Colorado Advance Medical Directive* is a **Colorado Organ Donation form**, which allows you to set out your wishes regarding organ donation. This can be especially helpful if you have not appointed an agent in Part One of your Colorado Advance Medical Directive to communicate those wishes for you.

This form does not expressly address mental illness. If you would like to make advance care plans involving mental illness, you should talk to your physician and an attorney about a durable power of attorney tailored to your needs.

Note: These documents will be legally binding only if the person completing them is a competent adult (at least 18 years old).

Completing Your Colorado Advance Medical Directive

Whom should I appoint as my agent?

Your agent is the person you appoint to make decisions about your medical care if you become unable to make those decisions yourself. Your agent may be a family member or a close friend whom you trust to make serious decisions. The person you name as your agent should clearly understand your wishes and be willing to accept the responsibility of making medical decisions for you.

You can appoint a second and third person as your alternate agent(s). The alternate(s) will step in if the first person you name as an agent is unable, unwilling, or unavailable to act for you.

Should I add personal instructions to my Colorado Advance Medical Directive?

One of the strongest reasons for naming an agent is to have someone who can respond flexibly as your medical situation changes and deal with situations that you did not foresee. If you add instructions to this document it may help your agent carry out your wishes, but be careful that you do not unintentionally restrict your agent's power to act in your best interest. In any event, be sure to talk with your agent about your future medical care and describe what you consider to be an acceptable "quality of life."

How do I make my Colorado Advance Medical Directive legal?

You must sign your advance medical directive in the presence of two witnesses. If you cannot do so yourself, you may direct someone to sign your advance medical directive for you.

The person signing on your behalf, at your direction, **cannot** be:

- A physician,
- An employee of your attending physician or of a health care facility in which you are a patient when you sign your document,
- A person with a claim against your estate, or
- A person entitled to any portion of your estate.

These witnesses **cannot** be:

- A person signing the document at your direction,
- A physician,
- An employee of your attending physician or of a health care facility in which you are a patient when you sign your document,
- A person with a claim against your estate, or
- A person entitled to any portion of your estate.

Completing Your Colorado Advance Medical Directive (Continued)

What if I change my mind?

You may revoke your Declaration orally, in writing, or by burning, tearing, canceling, obliterating, or destroying the document. Your doctor must be notified of your revocation for it to be effective.

Your agent must be notified for revocation of his/her authority to be effective.

Unless you specify otherwise in your declaration (Part Two), if you designate your spouse as your agent, that designation will automatically be revoked by divorce, dissolution or annulment of your marriage, or by a legal separation from your spouse.

What other important facts should I know?

Your declaration (Part Two) will not be honored while you are pregnant with a potentially viable fetus.

INSTRUCTIONS	
	COLORADO ADVANCE MEDICAL DIRECTIVE – PAGE 1 OF 5

Part One. Medical Durable Power of Attorney

PRINT YOUR NAME

I, ____, hereby
(your name)
appoint:

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR AGENT

____
(name of agent)

____
(home address of agent)

____
(work telephone number) (home telephone number)

as my agent to make health care decisions for me if and when I do not have the capacity to make my own health care decisions. This gives my agent the power to consent to giving, withholding or stopping any health care, treatment, service, or diagnostic procedure. My agent also has the authority to talk with health care personnel about my condition, access my medical records, get information and sign forms necessary to carry out those decisions. If the person named as my agent is not available or is unable or unwilling to act as my agent, then I appoint the following person(s) to serve in the order listed below:

PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST AND SECOND ALTERNATE AGENTS

1. ____
(name of first alternate)

____
(home address)

____
(work telephone number) (home telephone number)

2. ____
(name of second alternate)

____
(home address)

____
(work telephone number) (home telephone number)

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By this document I intend to create a Medical Durable Power of Attorney which shall take effect upon my incapacity to make my own health care decisions and shall continue during that incapacity.

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 Part Two (if I have filled out Part Two), 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 health care agent should make decisions for me that my health care agent believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.

(a) Additional Instruction:

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

____

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INSTRUCTIONS

Part Two. Declaration

PRINT YOUR NAME

I, ____,
(name)

being of sound mind and at least eighteen years of age, direct that my life shall not be artificially prolonged under the circumstances set forth below and hereby declare that:

If at any time my attending physician and one other qualified physician certify in writing that:

a. I have an injury, disease, or illness which is a terminal condition for which the administration of life-sustaining procedures will only serve to prolong the dying process and I am unable to make health care decisions, or

b. I am in a persistent vegetative state,

INITIAL ONLY ONE OPTION THAT REFLECTS YOUR WISHES

I direct that, in accordance with Colorado law, life-sustaining procedures shall be (Initial only the option that applies)

______ (Initials) I direct that life-sustaining procedures shall be withdrawn and/or withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nourishment considered necessary by the attending physician to provide comfort or alleviate pain.

IF YOU INITIAL THE SECOND CHOICE, YOU MUST CHOOSE THE NUMBER OF DAYS YOU WANT LIFE-SUSTAINING PROCEDURES CONTINUED

______ (Initials) I direct that life-sustaining procedures shall be continued for a period of not less than ______ days, and if there be no change in my condition which would indicate to my physicians that my prognosis has improved, then I direct that life-sustaining procedures shall be withdrawn and/or withheld pursuant to the terms of this declaration, it being understood that life-sustaining procedures shall not include any medical procedure or intervention for nourishment considered necessary by the attending physician to provide comfort or alleviate pain.

______ (Initials) I direct that life-sustaining procedures shall be continued indefinitely, regardless of my prognosis.

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In the event that the only procedure I am being provided is artificial nourishment, I direct that one of the following actions be taken: (initial the option that applies)

INITIAL ONLY ONE

______ (Initials) Artificial nourishment shall not be continued when it is the only procedure being provided; or

IF YOU INITIAL THE SECOND CHOICE, YOU MUST CHOOSE THE NUMBER OF DAYS YOU WANT ARTIFICIAL NOURISHMENT CONTINUED

______ (Initials) Artificial nourishment shall be continued for _______ days when it is the only procedure being provided; or

______ (Initials) Artificial nourishment shall be continued indefinitely when it is the only procedure being provided.

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

I further direct that:

____

____

____

____

____

____

____

____

____

In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my agent (if any), family, and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

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Part Three. Execution.

SIGN AND DATE THE DOCUMENT AND PRINT YOUR ADDRESS

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature:____

Date:____

Address:____

WITNESSING PROCEDURE

YOUR WITNESSES MUST SIGN, DATE, AND PRINT THEIR NAMES

WITNESSES

I declare that the person who signed or acknowledged this document ("the patient") is personally known to me, that he/she signed or acknowledged this Advance Medical Directive in my presence, and that he/she appears to be of sound mind and under no duress, fraud or undue influence. I did not sign this document for the patient. I am not the person appointed as the agent by this document. I am not a physician, nor am I the patient's health care provider, or an employee of the patient's health care provider. I have no claim on, nor am I entitled to, any portion of the patient's estate.

WITNESS #1

First Witness' Signature_______________________________________

Date____

Print Name ____

WITNESS #2

Second Witness' Signature_______________________________________

Date____

Print Name ____

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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

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COLORADO 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 Colorado 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 Colorado 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 ____

____

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You Have Filled Out Your Advance Directive, Now What?

1. Your *Colorado Advance Medical 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. 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.

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

6. Remember, you can always revoke your Colorado document.

7. Be aware that your 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.

   Colorado authorizes Medical Orders for Scope of Treatment (MOST forms), which allow you to specify the scope of treatment you receive, including the withholding of CPR. We suggest you speak to your physician if you are interested in obtaining one. **CaringInfo does not distribute these forms.**

Congratulations!

You've downloaded **your free, state specific advance directive.**

You are taking important steps to make sure your wishes are known. Help us keep this free.

Your generous support of the National Hospice Foundation and CaringInfo allows us to continue to provide these FREE resources, tools, and information to educate and empower individuals to access advance care planning, caregiving, hospice and grief services, and information.

I hope you will show your support for our mission and make a tax-deductible gift today.

Since 1992, the National Hospice Foundation has been dedicated to creating FREE resources for individuals and families facing a life-limiting illness, raising awareness for the need for hospice care, and providing ongoing professional education and skills development to hospice professionals across the nation.

Your gift strengthens the Foundation's ability to provide FREE caregiver and family resources.

Support your National Hospice Foundation by returning a **generous tax-deductible gift of $23, $47, $64,** or the most generous amount you can send.

You can help us provide resources like this advanced directive FREE by sending in your gift to help others.

Please help to make this possible with your contribution! Cut along the dotted line and use the coupon below to return a check contribution of the most generous amount you can send. Thank you.

- -

YES! I want to support the important work of the National Hospice Foundation.

- ☐ $23 helps us provide free advanced directives
- ☐ $47 helps us maintain our free HelpLine
- ☐ $64 helps us provide webinars to hospice professionals

Return to:
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Philadelphia, PA 19182-4401

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OR donate online today: www.caringinfo.org/donate