

EL DORADO COUNTY EMS AGENCY

FIELD POLICIE

Effective: July 1, 2015

Reviewed: July, 2016, 2017, 2019

Revised: December 14, 1016



EMS Agency Medical Director

DO NOT RESUSCITATE (DNR)/ DYING WITH DIGNITY

PURPOSE:

To establish criteria for a Do Not Resuscitate (DNR) Order and to thereby permit EMS Personnel to withhold resuscitative measures and medical interventions from patients in accordance with their wishes.

DEFINITIONS:

Do Not Resuscitate (DNR) - No chest compressions, no defibrillation, no assisted ventilation, no endotracheal intubation, and no cardiotoxic medications. This does not exclude treatment for airway obstruction, pain, dyspnea, or major hemorrhage.

DNR Form - Official State document developed by the California EMS Authority and the California Medical Association which allows a patient with a life threatening illness or injury to forgo resuscitative measures that may keep them alive.

Physician Orders for Life-Sustaining Treatment (POLST) - Official State document developed by the California State EMS Authority and the California Coalition for Compassionate Care, which allows a patient with a life threatening illness or injury to specify a type of intervention(s) or forgo specific resuscitative or life-sustaining measures that may keep them alive. EMS providers should be aware of different levels of care in Sections A and B. Section C does not apply to EMS personnel.

DNR Medallion - Medic Alert medallion which states Do Not Resuscitate - EMS or similar medallion as approved by the California EMS Authority.

Advanced Health Care Directive (AHCD) - An advance directive established in conformance with California statutory law by which an individual may give specific instructions about healthcare and/or name an agent to make health care decisions in the event the individual becomes unable to make such decisions for them self.

Aid in Dying Drug - A drug (or combination of drugs) prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to a terminal illness. The prescribed drug(s) may take effect within minutes to several days after self-administration.

End of Life Act - A California state law authorizes an adult, eighteen years or older, who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease, to make a request for an "aid in dying drug" from an authorized physician, prescribed for the purpose of ending his or her life in a humane and dignified manner.

PROCEDURE:

All patients with rapidly deteriorating vital signs or absent vital signs and who do not meet the determination of death criteria shall be resuscitated unless the field personnel are presented with:

Statewide Standards

- A completed and signed Prehospital DNR Request Form. **See Appendix A**
- A completed and signed POLST form. **See Appendix B**
- The patient is wearing a DNR medallion. **See Appendix C**

Medical Director Approved Documents

- A written, signed DNR order in the patient's medical record stating "Do Not Resuscitate", "No Code", or "No CPR" signed by a physician, with the patient's name and date
- A paper copy of the electronic medical record (EMR) order for DNR containing the physician name and date. **See Appendix D**
- An Advanced Health Care Directive. **See Appendix E**
- A verbal order from the patient's physician provided the physician immediately contacts and advises the base station
- EMS field personnel may discontinue resuscitation if the previously stated requirement(s) are satisfied
- If the paramedic is presented with any other type of written medical directive (not signed by physician) indicating patient's DNR request and/or family verbally states patient's DNR request, paramedics will contact base station for further direction
- EMS field personnel shall attempt to comply with partial or limited DNR orders (such as basic CPR, but no intubation, no drugs, or chemical code only) when such actions would not contradict other provisions of this policy
- Base station contact by the field personnel is not necessary prior to complying with a DNR order, but the base station should be informed as soon as possible. Base Hospital Physicians retain the authority for determining the appropriateness of resuscitation
- If a valid DNR order is present and the family requests resuscitation, begin resuscitation until the situation can be clarified. Usually discussions with the family will make attempted resuscitation unnecessary, contact base station for assistance
- If for any reason the DNR order does not seem to apply to the situation, resuscitation should be initiated and the base station contacted immediately
- Patients who are dead at the scene should not be transported by ambulance; however, for patients that collapse in public locations it may be necessary to transport to the hospital or other location in order to move the body to a place that provides the family with more privacy
- When resuscitative measures have begun and the decision is made to transport **OR** if resuscitation begins enroute, **Do Not** discontinue measures, continue to destination hospital or divert to nearest hospital
- Verification shall be accomplished by the following:
 - a. The presence of a DNR order, the physician's name signing the order, and the date of the order are to be documented on the Prehospital Care Report (PCR).
 - b. The DNR form (original or copy), DNR medallion, AHCD, POLST form, or a copy of the valid DNR order from the patient's medical record shall be taken with the patient.

There is no date of expiration for DNR.

END OF LIFE OPTION ACT

A person who has obtained an aid-in dying drug has met extensive and stringent California state law requirements. The law offers protections and exemptions for healthcare providers but is not clear or explicit regarding EMS responses to patients who have initiated the End of Life Option. The following guidelines are provided for EMS personnel when responding to a patient who has self-administered an aid-in-dying drug.

1. Within 48 hours of self-administering the aid-in-dying drug, the patient is required to complete a "Final Attestation For An Aid –in Dying Drug to End My Life in a Humane and Dignified Manner". However, there is no mandate for the patient to maintain the final attestation for directly or to keep it in close proximity to their person. If a copy of the final attestation is available, EMS personnel should confirm the patient is the person identified in the final attestation. This will normally require the presence of a form of identification or a person who can reliably identify the patient.
2. There are no standardized "Final Attestation forms", but the law has required specific information that must be on the Final Attestation:
 - The document is identified as a "Final Attestation For An aid-In-Dying Drug to End My Life in a Humane and Dignified Manner"
 - Patient's name and signature
 - The form is dated
3. Provide comfort measures and/or airway ventilation measures when applicable.
4. Withhold resuscitative measures if the patient is in cardiopulmonary arrest.
5. The patient may at any time withdraw or rescind his or her request for an aid-in-dying drug regardless of the patient's mental status. In this instance, EMS personnel shall provide medical care as per standard protocols. EMS personnel are encouraged to contact their base Hospital for further direction or concerns.

REFERENCES:

- 1) Recommended Guidelines for EMS Personnel regarding DNR and other Patient-Designated Directives Limiting Prehospital Care, EMSA # 311, Fifth Edition, October 2014
- 2) Coalition for Compassionate Care of California; <http://coalitionccc.org>
- 3) Advance Healthcare Directive; <http://ag.ca.gov/consumers/pdf/AHCDS1.pdf>

Appendix A

EMSA/CMA APPROVED PREHOSPITAL DNR FORM

1. Under the EMSA/CMA approved Prehospital DNR Form, do not resuscitate (DNR) means no chest compressions, defibrillation, endotracheal intubation, assisted ventilation, or cardiotoxic drugs.
2. The patient should receive all other care not identified above for all other medical conditions according to local protocols.
3. Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped and the patient is unconscious, ventilation should not be assisted.
4. Requests must be signed and dated by a physician. No witness to the patient's or surrogate's signature is necessary. Ensuring appropriate informed consent is the responsibility of the attending physician, not the EMS system or prehospital provider.
5. The DNR Form should be clearly posted or maintained near the patient in the home. A typical location might be in an envelope in a visible location near the patient's bed. Copies of the form are valid and will be honored. The patient or family should be encouraged to keep a copy in case the original is lost. The copy should be taken with the patient during transport.
6. In general, EMS personnel should see the written prehospital DNR Form unless the patient's physician is present and issues a DNR order.
7. Correct identification of the patient is crucial, but after a good faith attempt to identify the patient, the presumption should be that the identity is correct if documentation is present and the circumstances are consistent. There should be a properly completed standard EMSA/CMA DNR Form available with the patient. A witness who can reliably identify the patient is valuable.

CMA PUBLICATIONS 1(800) 692-1262 WWW.CMAA.ORG



EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM



An Advance Request to Limit the Scope of Emergency Medical Care

I, _____, request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will **not** prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

Patient/Legally Recognized Health Care Decisionmaker Signature _____ Date _____

Legally Recognized Health Care Decisionmaker's Relationship to Patient
By signing this form, the legally recognized health care decisionmaker acknowledges that this request to forego resuscitative measures is consistent with the known desires of, and with the best interest of, the individual who is the subject of the form.

I affirm that this patient/legally recognized health care decisionmaker is making an informed decision and that this directive is the expressed wish of the patient/legally recognized health care decisionmaker. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotoxic medications are to be initiated.

Physician Signature _____ Date _____

Print Name _____ Telephone _____

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY
PREHOSPITAL DNR REQUEST FORM

Appendix B

EMSA APPROVED POLST FORM

EMS personnel who encounter the EMSA approved POLST form in the field should be aware of the different levels of care in Sections A and B of the form (Section C does NOT apply to EMS personnel).

Section A

Section A applies only to individuals who do NOT have a pulse and are NOT breathing upon arrival of EMS personnel.

1. If an individual has checked "Attempt Resuscitation/CPR", then EMS personnel should treat the individual to the fullest extent possible according to local protocols regardless of what may be checked in Section B. For this individual this form as filled out does NOT constitute a DNR.
2. If the individual has checked "Do Not Attempt Resuscitation/DNR", then no attempts should be made to resuscitate the individual and the EMS personnel should follow their local policies, procedures and protocols for declaration of death.

Section B

Section B applies only to individuals who have checked "Do Not Attempt Resuscitation/DNR" in Section A AND who have a pulse and/or are breathing upon the arrival of EMS personnel.

1. If an individual has checked "Full Treatment" then they should be treated to the fullest extent possible. This includes, but is not limited to, intubation and other advanced airway interventions, mechanical ventilation and defibrillation/cardioversion.

Should the individual's condition deteriorate after EMS personnel have arrived and they have indicated "DNR" in Section A, then resuscitation efforts should be attempted up to, but NOT including, chest compressions. Then EMS personnel should follow local protocols regarding declaration of death.

EMS personnel shall ignore the check box marked "Trial Period of Full Treatment" as it is not applicable to pre-hospital care.

2. If an individual has checked "Selective Treatment" the following care may be provided (in addition to the care outlined below):
 - Administration of IV fluids
 - May use non-invasive positive airway pressure to include: continuous positive airway pressure (CPAP), bi-level positive airway pressure (BiPAP), and bag valve mask (BVM) assisted respirations according to local protocols. This does NOT include intubation
 - EMS personnel shall ignore the subjective phrase "avoid burdensome measures" when considering treatment options for the patient. EMS personnel shall follow

their local protocols, policies and procedures regarding patient treatments and if necessary contact medical control for further guidance

- EMS personnel shall ignore the check box marked “Request transfer to hospital only if comfort needs cannot be met in current location”. EMS personnel shall follow their local protocols, policies and procedures regarding patient transport
3. If an individual has checked “Comfort-Focused Treatment” the following care may be provided:
- The patient should receive full palliative treatment for pain, dyspnea, major hemorrhage, or other medical conditions (includes medication by any route) according to local protocols
 - Relief of choking caused by a foreign body is usually appropriate, although if breathing has stopped and the patient is unconscious, ventilation should not be assisted
 - EMS personnel shall ignore the statement “Request transfer to hospital only if comfort needs cannot be met in current location”. EMS personnel shall follow their local protocols, policies and procedures regarding patient transport
4. EMS personnel shall obtain online medical control prior to following any orders listed under “Additional Orders”.

EMSA approved POLST forms must be signed and dated by a physician and the patient or legally recognized decision-maker. No witness to the patient's or legally recognized decision-maker's signature is necessary. Ensuring appropriate informed consent is the responsibility of the attending physician, not the EMS system or prehospital provider.

The EMSA approved POLST form should be clearly posted or maintained near the patient. A typical location might be in an envelope in a visible location near the patient's bed. Copies of the form are valid and will be honored. The patient or family should be encouraged to keep a copy in case the original is lost. The copy should be taken with the patient during transports.

In general, EMS personnel should see the written EMSA approved POLST form unless the patient's physician is present and issues a DNR order.

Correct identification of the patient is crucial, but after a good faith attempt to identify the patient, the presumption should be that the identity is correct if documentation is present and the circumstances are consistent. There should be a properly completed EMSA approved POLST form available with the patient. A witness who can reliably identify the patient is valuable.

| HIPAA PERMITS DISCLOSURE OF POLST TO OTHER HEALTHCARE PROVIDERS AS NECESSARY | | | | | | | | | | | | | | |
|---|---|---|-----------------------|-------------------------|---------------------------|---------------------------------|----------------------|------------------------------|-------------|---------------------------------------|-----------------------|-------|--|--------------------------------|
|  <p>EMSA #111 B (Effective 10/1/2014)*</p> | <p style="text-align: center;">Physician Orders for Life-Sustaining Treatment (POLST)</p> <p><small>First follow these orders, then contact physician. A copy of the signed POLST form is a legally valid physician order. Any section not completed implies full treatment for that section. POLST complements an Advance Directive and is not intended to replace that document.</small></p> | <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="padding: 2px;">Patient Last Name:</td> <td style="padding: 2px;">Date Form Prepared:</td> </tr> <tr> <td style="padding: 2px;">Patient First Name:</td> <td style="padding: 2px;">Patient Date of Birth:</td> </tr> <tr> <td style="padding: 2px;">Patient Middle Name:</td> <td style="padding: 2px;">Medical Record #: (optional)</td> </tr> </table> | Patient Last Name: | Date Form Prepared: | Patient First Name: | Patient Date of Birth: | Patient Middle Name: | Medical Record #: (optional) | | | | | | |
| Patient Last Name: | Date Form Prepared: | | | | | | | | | | | | | |
| Patient First Name: | Patient Date of Birth: | | | | | | | | | | | | | |
| Patient Middle Name: | Medical Record #: (optional) | | | | | | | | | | | | | |
| A | <p>CARDIOPULMONARY RESUSCITATION (CPR): <i>If patient has no pulse and is not breathing.</i></p> <p style="text-align: center;"><i>If patient is NOT in cardiopulmonary arrest, follow orders in Sections B and C.</i></p> <p><input type="checkbox"/> Attempt Resuscitation/CPR (Selecting CPR in Section A requires selecting Full Treatment in Section B)</p> <p><input type="checkbox"/> Do Not Attempt Resuscitation/DNR (Allow Natural Death)</p> | | | | | | | | | | | | | |
| B | <p>MEDICAL INTERVENTIONS: <i>If patient is found with a pulse and/or is breathing.</i></p> <p><input type="checkbox"/> Full Treatment – primary goal of prolonging life by all medically effective means. In addition to treatment described in Selective Treatment and Comfort-Focused Treatment, use intubation, advanced airway interventions, mechanical ventilation, and cardioversion as indicated. <input type="checkbox"/> Trial Period of Full Treatment.</p> <p><input type="checkbox"/> Selective Treatment – goal of treating medical conditions while avoiding burdensome measures. In addition to treatment described in Comfort-Focused Treatment, use medical treatment, IV antibiotics, and IV fluids as indicated. Do not intubate. May use non-invasive positive airway pressure. Generally avoid intensive care. <input type="checkbox"/> Request transfer to hospital only if comfort needs cannot be met in current location.</p> <p><input type="checkbox"/> Comfort-Focused Treatment – primary goal of maximizing comfort. Relieve pain and suffering with medication by any route as needed; use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Request transfer to hospital only if comfort needs cannot be met in current location.</p> <p>Additional Orders: _____</p> | | | | | | | | | | | | | |
| C | <p>ARTIFICIALLY ADMINISTERED NUTRITION: <i>Offer food by mouth if feasible and desired.</i></p> <p><input type="checkbox"/> Long-term artificial nutrition, including feeding tubes. Additional Orders: _____</p> <p><input type="checkbox"/> Trial period of artificial nutrition, including feeding tubes. _____</p> <p><input type="checkbox"/> No artificial means of nutrition, including feeding tubes. _____</p> | | | | | | | | | | | | | |
| D | <p>INFORMATION AND SIGNATURES:</p> <p>Discussed with: <input type="checkbox"/> Patient (Patient Has Capacity) <input type="checkbox"/> Legally Recognized Decisionmaker</p> <p><input type="checkbox"/> Advance Directive dated _____, available and reviewed → Healthcare Agent if named in Advance Directive: <input type="checkbox"/> Advance Directive not available Name: _____ <input type="checkbox"/> No Advance Directive Phone: _____</p> <p>Signature of Physician My signature below indicates to the best of my knowledge that these orders are consistent with the patient's medical condition and preferences.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 40%; padding: 2px;">Print Physician Name:</td> <td style="width: 20%; padding: 2px;">Physician Phone Number:</td> <td style="width: 40%; padding: 2px;">Physician License Number:</td> </tr> <tr> <td style="padding: 2px;">Physician Signature: (required)</td> <td colspan="2" style="padding: 2px;">Date:</td> </tr> </table> <p>Signature of Patient or Legally Recognized Decisionmaker I am aware that this form is voluntary. By signing this form, the legally recognized decisionmaker acknowledges that this request regarding resuscitative measures is consistent with the known desires of, and with the best interest of, the patient who is the subject of the form.</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width: 60%; padding: 2px;">Print Name:</td> <td style="width: 40%; padding: 2px;">Relationship: (write self if patient)</td> </tr> <tr> <td style="padding: 2px;">Signature: (required)</td> <td style="padding: 2px;">Date:</td> </tr> <tr> <td style="padding: 2px;">Mailing Address (street/city/state/zip):</td> <td style="padding: 2px;">Phone Number: Office Use Only:</td> </tr> </table> | | Print Physician Name: | Physician Phone Number: | Physician License Number: | Physician Signature: (required) | Date: | | Print Name: | Relationship: (write self if patient) | Signature: (required) | Date: | Mailing Address (street/city/state/zip): | Phone Number: Office Use Only: |
| Print Physician Name: | Physician Phone Number: | Physician License Number: | | | | | | | | | | | | |
| Physician Signature: (required) | Date: | | | | | | | | | | | | | |
| Print Name: | Relationship: (write self if patient) | | | | | | | | | | | | | |
| Signature: (required) | Date: | | | | | | | | | | | | | |
| Mailing Address (street/city/state/zip): | Phone Number: Office Use Only: | | | | | | | | | | | | | |
| SEND FORM WITH PATIENT WHENEVER TRANSFERRED OR DISCHARGED | | | | | | | | | | | | | | |

Appendix C

DNR MEDALLION



Appendix D

EXAMPLES OF APPROVED ELECTRONIC DNR ORDERS

File Edit List Options Functions Window Help

Order Entry | Diet Order | Change Order | Verify Order | Order Inquiry | Charge Release | Batch Charge

Height: 60.00 in Weight: 76.30 kg Age: 90 Years Allergy: Aspirin

Order Code: DNR DNR Type: CO Order number: 23

Frequency: CONT Ord Phys: BARNHILL, BRADLEY WILLIAM

Start Date: 02/04/2015 04:02 Stop Date: 00/00/0000 00:00 # Days:

SpclAttn:

Instructions:

Reference:

PARAGON 3.0 ENTERPRISE 1045 MARSHALL WAY PLACERVILLE, CA 95667 (530)622-1441
Printed By: DIRICKX, AMY F. at 09:01 AM on 2015 Feb 05

Non Pharmacy Orders

Visit ID
Med Rec #

Admitted: 02/04/2015 01:50
Location: INTENSIVE CARE UNIT - 0400-08

Name:
Sex:
Birth Date:

Visit ID: 2129696
Description: DNR
Alt Description:
Order # 23
Priority:
Order Status: Active
Days:

Code: DNR
Frequency: CONT
Order Start Date: 02/04/2015 04:02

Type: CODE STATUS
Ordered By: BARNHILL, BRADLEY W.
Order Stop Date: 00/00/0000 00:00

Special Attn:
Reference Data:
Instructions:
Prep Detail:

EL DORADO COUNTY EMS AGENCY FIELD POLICIE

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Appendix E

EXAMPLES OF ADVANCED HEALTH CARE DIRECTIVE

| | | |
|---|---|---|
| <p>INSTRUCTIONS</p> <p>PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR PRIMARY AGENT</p> <p>PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR FIRST ALTERNATE AGENT (OPTIONAL)</p> <p>PRINT THE NAME, HOME ADDRESS AND HOME AND WORK TELEPHONE NUMBERS OF YOUR SECOND ALTERNATE AGENT (OPTIONAL)</p> <p>© 2005 National Hospice and Palliative Care Organization 2014 Revised.</p> | <p>CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE — PAGE 3 OF 13</p> <p>PART 1: POWER OF ATTORNEY FOR HEALTH CARE</p> <p>(1) DESIGNATION OF AGENT: I designate the following individual as my agent to make health care decisions for me:</p> <p>_____ (Name of individual you choose as agent)</p> <p>_____ (address) (city) (state) (zip code)</p> <p>_____ (home phone) (work phone)</p> <p>OPTIONAL: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my first alternate agent:</p> <p>_____ (Name of individual you choose as first alternate agent)</p> <p>_____ (address)</p> <p>_____ (city) (state) (zip code)</p> <p>_____ (home phone) (work phone)</p> <p>OPTIONAL: If I revoke the authority of my agent and first alternate agent or if neither is willing, able, or reasonably available to make a health care decision for me, I designate as my second alternate agent:</p> <p>_____ (Name of individual you choose as second alternate agent)</p> <p>_____ (address)</p> <p>_____ (city) (state) (zip code)</p> <p>_____ (home phone) (work phone)</p> | <p>CALIFORNIA ADVANCE HEALTH CARE DIRECTIVE — PAGE 4 OF 13</p> <p>ADD INSTRUCTIONS HERE ONLY IF YOU WANT TO LIMIT THE POWER OF YOUR AGENT</p> <p>(2) AGENT'S AUTHORITY: My agent is authorized to make all health care decisions for me, including decisions to provide, withhold, or withdraw artificial nutrition and hydration, and all other forms of health care to keep me alive, except as I state here:</p> <p>_____ _____ _____ (Add additional sheets if needed.)</p> <p>(3) WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE: My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box. If I mark this box [<input type="checkbox"/>], my agent's authority to make health care decisions for me takes effect immediately.</p> <p>INITIAL THE BOX IF YOU WISH YOUR AGENT'S AUTHORITY TO BECOME EFFECTIVE IMMEDIATELY</p> <p>(4) AGENT'S OBLIGATION: My agent shall make health care decisions for me in accordance with this power of attorney for health care, any instructions I give in Part 2 of this form, and my other wishes to the extent known to my agent. To the extent my wishes are unknown, my agent shall make health care decisions for me in accordance with what my agent determines to be in my best interest. In determining my best interest, my agent shall consider my personal values to the extent known to my agent.</p> <p>CROSS OUT AND INITIAL ANY STATEMENTS IN PARAGRAPHS 4, 5, OR 6 THAT DO NOT REFLECT YOUR WISHES</p> <p>(5) AGENT'S POSTDEATH AUTHORITY: My agent is authorized to make anatomical gifts, authorize an autopsy, and direct disposition of my remains, except as I state here, in paragraph (2) above, or in Part 3 of this form:</p> <p>_____ _____ _____</p> <p>(6) NOMINATION OF CONSERVATOR: If a conservator of my person needs to be appointed for me by a court, I nominate the agent designated in this form. If that agent is not willing, able, or reasonably available to act as conservator, I nominate the alternate agents whom I have named, in the order designated.</p> <p>© 2005 National Hospice and Palliative Care Organization 2014 Revised.</p> |
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