

# Emergency Response Wishes

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I want all resuscitation procedures implemented in an emergency situation. (Initials: \_\_\_\_\_)

I wish to decline any medical treatment that does not provide reasonable benefit to my current condition and allow a natural death (A-N-D):

I do not want CPR if my heart stops \_\_\_\_\_Initials **DNR**

I do not want to be intubated for breathing assistance \_\_\_\_\_Initials **DNI**

I understand that all therapeutic measures will be directed to alleviate my suffering/and or pain and maximize my comfort and dignity.

**My Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please Check:  Patient  MDPOA  Proxy  Appointed Guardian

**Medical Provider:** \_\_\_\_\_ (print) Phone: \_\_\_\_\_

**Signature (recommended, not required):** \_\_\_\_\_ Date: \_\_\_\_\_

## Appointment of my MDPOA (Medical Durable Power of Attorney)

The person I appoint to and communicate my health care decisions when I cannot. This gives My Agent the power to consent to, refuse or stop any health care, treatment, service or diagnostic procedure. My agent also has the authority to talk with health care personnel, get information and sign forms as necessary to carry out those decisions. *(Note: This designation supersedes any previously completed MDPOA form.)*  
My MDPOA is:

My Agent: \_\_\_\_\_ Phone#: \_\_\_\_\_

If that person is unreachable, I appoint:

My Agent (2): \_\_\_\_\_ Phone#: \_\_\_\_\_

**My Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

### Witnesses (Optional):

Witness # 1: \_\_\_\_\_ Witness # 2: \_\_\_\_\_

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

**NOTE:** Please take this form to your medical provider to scan into QHN

Nursing home patients, hospitalized patients and many assisted living residents will need a M.O.S.T. form completed.

## Recommendations:

- ❑ Discuss these wishes with your close family members and those persons you will ask to make medical decisions if you are unable to do so.
- ❑ Take to your primary physician to sign and upload into Quality Health Network (QHN), the regional health information exchange. Providers note: Instructions for uploading this form are available under the Resources tab, QHN System Tip Sheets, at: [www.qualityhealthnetwork.org](http://www.qualityhealthnetwork.org).
- ❑ Keep this in a “butterfly folder” on your refrigerator. This folder is used to notify emergency personnel of your wishes and may be taken with you if you are admitted to the hospital.
- ❑ For ease of access in an emergency, complete a Medical Durable Power of Attorney (MDPOA) wallet card with this information. Cards are available at [www.hopewestco.org](http://www.hopewestco.org) or at your doctor’s office.
- ❑ How to revoke this document or change MDPOA or desires: remove and destroy this form from your folder and complete a new form.
- ❑ New forms can be found at [www.hopewestco.org](http://www.hopewestco.org) or you may ask your health care provider.
- ❑ Questions can be answered at HopeWest (970-241-2212)