

Advance Care Planning

What is advance care planning?

Advance care planning is the process of making known your wishes and instructions for your care in writing or verbally to your friends and family if needed in the future. Anyone 18 and older should have an advance care plan. Advance care planning information is used when you cannot make health care decisions for yourself. This information also may help guide decisions made by your health care agent or, if you do not have an agent, then by your family members.

Advance care planning may include decisions about:

- Your health care agent - the person who will speak for you if you cannot
- Cardiopulmonary Resuscitation (CPR) - what to do if your heart stops
- Respirators - what to do if you cannot breathe on your own
- IV hydration - getting fluid into your veins
- Feeding tubes - what to do if you cannot swallow

What kind of information should you document in an advance care plan?

- Health Care Proxy– choosing a person who will make health care decisions for you if you cannot
- Organ donation choice – such as made on your driver’s license or voter registration form
- Do Not Resuscitate (DNR) instructions
- Advance directives, which are legal, written instructions describing your preferences

For people with serious and potentially life threatening illnesses, a doctor, nurse practitioner or physician assistant can use the Medical Orders for Life-Sustaining Treatment (MOLST) or the Physician’s Orders for Life Sustaining Treatment (POLST) form to document your treatment preferences concerning life sustaining treatments.

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