Optimum Internal Medicine & Pediatrics
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PATIENT AND CARE PARTNER GUIDE

Advance Care Planning

Prepare for a conversation about the care that matters to you.

This guide and worksheet help start a conversation. They do not appoint a health care agent, authorize release of information, or create or change a treatment order. Use the official forms for legal instructions and medical orders.

Start with what matters to you

Planning can help before a serious illness or injury, not only near the end of life. Think about your goals, beliefs, worries, and the people you trust. You may ask questions, take more time, and revisit the conversation as your situation changes.

Tennessee Advance Directive for Health Care

The official form lets you name a health care agent in **Part 1** and record care preferences in **Part 2**. You may use those parts together or separately; mark out or void any unused part.

Discuss the **When Effective** choice carefully. The form allows you to authorize your agent to act even while you can make your own decisions, or only when you no longer have capacity.

Follow the official **Part 5 signing instructions**: use either two qualified adult witnesses or a notary. Neither witness may be your agent or alternate; at least one must be unrelated to you and not entitled to your estate. Ask the care team for help before signing.

POST is a separate medical order

A Tennessee POST form translates a discussion about current health and goals into medical orders. It is intended for seriously ill or frail patients and is not needed by everyone. The appropriate clinician completes and signs it after discussion with the patient or authorized decision-maker. Follow current official POST signing requirements; authority varies by clinician type and setting. Do not choose CPR or other treatment orders on this worksheet.

Bring your documents and questions

Bring any existing advance directive, health care power of attorney, living will, POST, or other treatment orders. Ask the team to check for outdated or conflicting documents. Keep copies accessible and share the appropriate completed forms with your care team and health care agent.

Privacy: Bring the completed worksheet to your visit or use a clinic-approved secure method. Do not enter personal health information on the public website.

Official directive: packet pages 3-4. Follow its signing instructions on packet page 4 (the official form's page 2). Keep both pages together.

Sources: Tennessee Health Facilities Commission, Advance Directive for Health Care and POST resources.
tn.gov/content/dam/tn/hfc/documents/Advance_Directive_for_Health_Care.pdf
tn.gov/content/dam/tn/health/healthprofboards/hcf/POST_Form_FAQ.pdf (POST overview; clinician verifies current requirements.)

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PATIENT WORKSHEET AND STAFF REVIEW

Discussion Worksheet

Optional notes for your visit. Leave any item blank if you are unsure.

Patient name _____ Date of birth _____

Visit date _____ Completed with or by _____

Patient or care partner notes

What matters most to me in my health and daily life?

My questions, worries, beliefs, or concerns for the care team

A person I trust and may want to discuss as my health care agent

Name _____ Relationship _____

Phone _____

Listing someone here does not appoint an agent or grant legal authority.

Documents I already have

- ☐ Advance directive / living will
- ☐ Health care power of attorney
- ☐ POST / other medical orders
- ☐ None
- ☐ Unsure

Where the documents or copies can be found _____

Staff use only

- ☐ Review goals, questions, and who participated in the discussion.
- ☐ Reconcile existing directives and orders; route conflicts to the clinician.
- ☐ Confirm agent information and the directive's When Effective selection.
- ☐ If a directive is completed, check all official signing requirements.
- ☐ Ask the clinician whether POST is appropriate; do not preselect orders.
- ☐ Provide copies, record where documents are kept, and plan follow-up.

Next step / follow-up _____

ADVANCE DIRECTIVE FOR HEALTH CARE*
(Tennessee)

Instructions: Parts 1 and 2 may be used together or independently. Please mark out/void any unused part(s). Part 5, Block A or Block B must be completed for all uses.

I, _____, hereby give these advance instructions on how I want to be treated by my doctors and other health care providers when I can no longer make those treatment decisions myself.

Part I **Agent:** I want the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

Alternate Agent: If the person named above is unable or unwilling to make health care decisions for me, I appoint as alternate the following person to make health care decisions for me. This includes any health care decision I could have made for myself if able, except that my agent must follow my instructions below:

Name: _____ Relation: _____ Home Phone: _____ Work Phone: _____
Address: _____ Mobile Phone: _____ Other Phone: _____

My agent is also my personal representative for purposes of federal and state privacy laws, including HIPAA.

When Effective (mark one): ☐ I give my agent permission to make health care decisions for me at any time, even if I have capacity to make decisions for myself. ☐ I do not give such permission (this form applies only when I no longer have capacity).

Part 2 **Indicate Your Wishes for Quality of Life:** By marking "yes" below, I have indicated conditions I would be willing to live with if given adequate comfort care and pain management. By marking "**no**" below, I have indicated conditions I would not be willing to live with (that to me would create an **unacceptable** quality of life).

☐ Yes ☐ No	**Permanent Unconscious Condition:** I become totally unaware of people or surroundings with little chance of ever waking up from the coma.
☐ Yes ☐ No	**Permanent Confusion:** I become unable to remember, understand, or make decisions. I do not recognize loved ones or cannot have a clear conversation with them.
☐ Yes ☐ No	**Dependent in all Activities of Daily Living:** I am no longer able to talk or communicate clearly or move by myself. I depend on others for feeding, bathing, dressing, and walking. Rehabilitation or any other restorative treatment will not help.
☐ Yes ☐ No	**End-Stage Illnesses:** I have an illness that has reached its final stages in spite of full treatment. Examples: Widespread cancer that no longer responds to treatment; chronic and/or damaged heart and lungs, where oxygen is needed most of the time and activities are limited due to the feeling of suffocation.

Indicate Your Wishes for Treatment: If my quality of life becomes unacceptable to me (as indicated by one or more of the conditions marked "no" above) and my condition is irreversible (that is, it will not improve), I direct that medically appropriate treatment be provided as follows. By marking "yes" below, I have indicated treatment I want. By marking "**no**" below, I have indicated treatment I **do not want**.

☐ Yes ☐ No	**CPR (Cardiopulmonary Resuscitation):** To make the heart beat again and restore breathing after it has stopped. Usually this involves electric shock, chest compressions, and breathing assistance.
☐ Yes ☐ No	**Life Support / Other Artificial Support:** Continuous use of breathing machine, IV fluids, medications, and other equipment that helps the lungs, heart, kidneys, and other organs to continue to work.
☐ Yes ☐ No	**Treatment of New Conditions:** Use of surgery, blood transfusions, or antibiotics that will deal with a new condition but will not help the main illness.
☐ Yes ☐ No	**Tube feeding/IV fluids:** Use of tubes to deliver food and water to a patient's stomach or use of IV fluids into a vein, which would include artificially delivered nutrition and hydration.

PLEASE SIGN ON PAGE 2

Part 3 **Other instructions, such as hospice care, burial arrangements, etc.:** _____

_____

_____

_____

_____

(Attach additional pages if necessary)

Part 4 Organ donation: Upon my death, I wish to make the following anatomical gift for purposes of transplantation, research, and/or education (mark one):

☐ Any organ/tissue ☐ My entire body ☐ Only the following organs/tissues: _____

_____

☐ No organ/tissue donation

SIGNATURE

Part 5 Your signature must **either** be witnessed by two competent adults ("Block A") **or** by a notary public ("Block B").

Signature: _____ Date: _____
(Patient)

_____

Block A Neither witness may be the person you appointed as your agent or alternate, and at least one of the witnesses must be someone who is not related to you or entitled to any part of your estate.

Witnesses:

1. I am a competent adult who is not named as the agent. I witnessed the patient's signature on this form.

_____
Signature of witness number 1

2. I am a competent adult who is not named as the agent. I am not related to the patient by blood, marriage, or adoption and I would not be entitled to any portion of the patient's estate upon his or her death under any existing will or codicil or by operation of law. I witnessed the patient's signature on this form.

_____
Signature of witness number 2

_____

Block B You may choose to have your signature witnessed by a notary public instead of the witnesses described in Block A.

STATE OF TENNESSEE
COUNTY OF _____

I am a Notary Public in and for the State and County named above. The person who signed this instrument is personally known to me (or proved to me on the basis of satisfactory evidence) to be the person who signed as the "patient." The patient personally appeared before me and signed above or acknowledged the signature above as his or her own. I declare under penalty of perjury that the patient appears to be of sound mind and under no duress, fraud, or undue influence.

My commission expires: _____ _____
Signature of Notary Public

WHAT TO DO WITH THIS ADVANCE DIRECTIVE: (1) provide a copy to your physician(s); (2) keep a copy in your personal files where it is accessible to others; (3) tell your closest relatives and friends what is in the document; (4) provide a copy to the person(s) you named as your health care agent.

* This form replaces the old forms for durable power of attorney for health care, living will, appointment of agent, and advance care plan, and eliminates the need for any of those documents.

GETTING YOUR AFFAIRS IN ORDER:
Advance Care Planning

Making healthcare decisions for yourself or someone who is no longer able to do so can be overwhelming. That's why it's important to get a clear idea about preferences and arrangements while you can make decisions and participate in legal and financial planning together.

Use this checklist to ensure healthcare and financial arrangements are in place before serious illness or a healthcare crisis.

- [x] **Start discussions** early with your loved one while everyone can still help make decisions.



- [x] **Create documents** that communicate **healthcare**, **financial management**, and **end of life** wishes for yourself and the people you care for, with legal advice as needed.



- [x] **Review plans regularly**, and update documents as circumstances change.



- [x] **Put important papers in one place**. Make sure a trusted family member or friend knows the location and any instructions.



- [x] **Make copies** of **healthcare directives** to be placed in all medical files, including information on every doctor seen.



- [x] **Give permission** in advance for a doctor or lawyer to talk directly with a caregiver as needed.



- [x] **Reduce anxiety** about funeral and burial arrangements by planning ahead.



Visit https://www.nia.nih.gov/health/caregiving/advance-care-planning to learn more about advance care planning.

NIH National Institute on Aging

Advance Directive
NOTIFICATION

Print name _____ Signature _____

❑ I have a health care power of attorney ❑ I have an advance directive

I have talked with my family and my doctor about the care I want. If I am unable to speak for myself, please contact:

Name _____ Number _____
(Additional names on back)

Fold

For more information visit:
www.aha.org/putitinwriting

Your life. Your terms.

Name _____ Number _____

Name _____ Number _____

Name _____ Number _____

Directions for Health Care Professionals

Completing POST

Must be completed by a health care professional based on patient preferences, patient best interest, and medical indications.

To be valid. POST must be signed by a physician or, at discharge or transfer from a hospital or long term care facility, by a nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA). Verbal orders are acceptable with follow-up signature by physician in accordance with facility/community policy.

Person with DNR in effect at time of discharge must have POST completed by health care facility prior to discharge and copy of POST provided to qualified medical emergency personnel.

Photocopies/faxes of signed POST forms are legal and valid.

Using POST

Any incomplete section of POST implies full treatment for that section.

No defibrillator (including AEDs) should be used on a person who has chosen "Do Not Attempt Resuscitation".

Oral fluids and nutrition must always be offered if medically feasible.

When comfort cannot be achieved in the current setting, the person, including someone with "Comfort Measures Only", should be transferred to a setting able to provide comfort (e.g., treatment of a hip fracture).

IV medication to enhance comfort may be appropriate for a person who has chosen "Comfort Measures Only".

Treatment of dehydration is a measure which prolongs life. A person who desires IV fluids should indicate "Limited Interventions" or "Full Treatment".

A person with capacity, or the Health Care Agent or Surrogate of a person without capacity, can request alternative treatment.

Reviewing POST

This POST should be reviewed if:

(1) The patient is transferred from one care setting or care level to another, or
(2) There is a substantial change in the patient's health status, or
(3) The patient's treatment preferences change.

Draw line through sections A through D and write "VOID" in large letters if POST is replaced or becomes invalid.

COPY OF FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED.

TN Department of Health **Division of Health Licensure and Regulation, Office of Health Care Facilities, 665 Mainstream Drive, Second Floor, Nashville, TN 37228**

A COPY OF THIS FORM SHALL ACCOMPANY PATIENT WHEN TRANSFERRED OR DISCHARGED

Tennessee Physician Orders for Scope of Treatment (POST, sometime called "POLST")

This is a Physician Order Sheet based on the medical conditions and wishes of the person identified at right ("patient"). Any section not completed indicates full treatment for that section. When need occurs, first follow these orders, then contact physician.

Patient's Last Name

First Name/Middle Initial

Date of Birth

Section A *Check One Box Only*

CARDIOPULMONARY RESUSCITATION (CPR): Patient has no pulse and is not breathing.

☐ **Resuscitate (CPR)** ☐ **Do Not Attempt Resuscitation (DNR / no CPR) (Allow Natural Death)**

When not in cardiopulmonary arrest, follow orders in **B, C,** and **D.**

Section B

Check One Box Only

MEDICAL INTERVENTIONS. Patient has pulse and/or is breathing.

☐ **Comfort Measures Only.** Relieve pain and suffering through the use of any medication by any route, positioning, wound care and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. **Do not transfer to hospital for life-sustaining treatment. Transfer only if comfort needs cannot be met in current location. Treatment Plan: Maximize comfort through symptom management.**

☐ **Limited Additional Interventions.** In addition to care described in Comfort Measures Only above, use medical treatment, antibiotics, IV fluids and cardiac monitoring as indicated. No intubation, advanced airway interventions, or mechanical ventilation. May consider less invasive airway support (e.g. CPAP, BiPAP). **Transfer** to hospital if indicated. Generally avoid the intensive care unit. **Treatment Plan: basic medical treatment.**

☐ **Full Treatment.** In addition to care described in Comfort Measures Only and Limited Additional Interventions above, use intubation, advanced airway interventions, and mechanical ventilation as indicated. **Transfer** to hospital and/or intensive care unit if indicated. **Treatment Plan: Full treatment including in the intensive care unit.**

*Other Instructions:*_____

Section C

Check One

ARTIFICIALLY ADMINISTERED NUTRITION. Oral fluids & nutrition must be offered if feasible.

☐ No artificial nutrition by tube.
☐ Defined trial period of artificial nutrition by tube.
☐ Long-term artificial nutrition by tube.

*Other Instructions:*_____

Section D

Must be Completed

Discussed with:
☐ Patient/Resident
☐ Health care agent
☐ Court-appointed guardian
☐ Health care surrogate
☐ Parent of minor
☐ Other: _____(Specify)

The Basis for These Orders Is: (Must be completed)
☐ Patient's preferences
☐ Patient's best interest (patient lacks capacity or preferences unknown)
☐ Medical indications
☐ (Other) _____

Physician/NP/CNS/PA Name (Print)	**Physician/NP/CNS/PA Signature** **Date** NP/CNS/PA (Signature at Discharge)	**MD/NP/CNS/PA Phone Number:** ( )

Signature of Patient, Parent of Minor, or Guardian/Health Care Representative

Preferences have been expressed to a physician and /or health care professional. It can be reviewed and updated at any time if your preferences change. If you are unable to make your own health care decisions, the orders should reflect your preferences as best understood by your agent/surrogate.

Name (Print)	Signature	Relationship (write "self" if patient)

Agent/Surrogate	Relationship	Phone Number ( )

Health Care Professional Preparing Form	Preparer Title	Phone Number ( )	Date Prepared