MedStar Health

At MedStar Health, it is important for us to understand your wishes about your care.

We are reaching out to all our patients over the age of 65 to share some ways we can improve our communication.

1. Tell us your concerns.
We want to know what is important to you. We are sharing a checklist you can use to help you think about this. If you want, you can complete the included checklist and bring it to your next appointment.

2. Share your health information with family or a friend.
Through myMedStar patient portal you may view your electronic health record, schedule visits, and message your provider. Sharing access to myMedStar patient portal with a family member or friend can help them better understand your health and treatments. Attached is information about how to share access to myMedStar patient portal, if you are interested.

3. Talk with your health team about your wishes.
We want to make sure your wishes are known and respected. If you'd like, you may complete the included advance directive form to bring to your next appointment to discuss with your primary care provider. If you already have an advance directive, you may bring a copy instead of completing a new one. Or you can create an electronic advance directive for free at **https://mydirectives.com/medstar**. A member of our clinic team may reach out to you prior to the visit to see if you have questions or would like to discuss further.

Give our team a call 410-829-2212 or email us at ACPInfo@MedStar.net to schedule today.

We look forward to talking with you on future visits and addressing your questions.

It's how we treat people.

MedStar Health

Making the most of your visit.

You may use this guide to prepare for primary care visits.

What do you want to discuss with your provider today?

Decide which concerns are most important. If you attend visits with a family member or friend, discuss which concerns are most important together. Mark (x) all that apply.

Patient health issues	Patient	Family
Hearing or vision	☐	☐
Fear of falls, dizziness, or balance	☐	☐
Bladder or bowel problems	☐	☐
Safety at home or when driving	☐	☐
Difficulty bathing, dressing, or walking	☐	☐
Financial matters that affect patient health	☐	☐
Planning for serious illness or progression of current illness	☐	☐
Changes in personality or behavior	☐	☐
Stress, worry, or feeling sad or blue	☐	☐
Trouble concentrating or making decisions	☐	☐
Memory problems	☐	☐
Managing or taking medications	☐	☐
_____	☐	☐
_____	☐	☐

If a family member or friend is involved, how can they be most helpful?

Together, decide what types of help you would like. Mark (x) all that apply.

- Listen and remember what the primary care provider says or means ☐
- Prompt you to ask questions or tell the primary care provider your concerns ☐
- Ask the primary care provider questions or give the care provider information directly ☐
- Allow you time alone with the primary care provider for some or all of the visit ☐
- Have my family member join my visit by phone. Phone:_____ ☐

How do you want to manage your health information after your visit?

Through myMedStar patient portal, you may view your electronic health record, schedule visits, and message your provider. If you are interested, the front desk can help set this up. Mark (x) if you are interested.

- I would like to set up access to myMedStar patient portal for myself ☐
- I would like to share access to myMedStar patient portal with a family member or friend. ☐

MedStar Health

myMedStar Patient Portal Access Authorization Form
For Use or Disclosure of Health Information

Completion of this authorization is required for both proxy access and/or minor patient self-access to the myMedStar Patient Portal. Please complete all fields and print legibly to ensure timely and accurate processing. For minor patients (under 18), requests must be made in person by the parent/legal guardian. For adult patients, requests for Proxy Access must be made in person by *either* the Personal Representative (person requesting access) or the adult patient.

Type of Access Requested (select one):

Proxy **OR** Self-access (Patients age 13-17)

- ☐ Patient under 18
- ☐ Adult patient
- ☐ Parental consent (see below*)
- ☐ Patient is an emancipated minor (attach documentation)

Relationship to patient:

- ☐ Self
- ☐ Parent
- ☐ Legal Guardian
- ☐ Health Care Power of Attorney
- ☐ Other:_____

Patient Information:

Patient Name (Last) _____ (First) _____ (MI) _____

Phone_____ SSN (*last 4 digits)* _____ DOB _____

Patient Signature _____ Time_____ Date_____

(Adult patients and patients ages 13-18 requesting self-access)

Email address for portal account (REQUIRED)

Proxy or Parent Permission Information: (All fields required for access, except emancipated minor status)

Full Name _____

Street Address _____

City _____ State _____ Zip Code _____

Phone _____ DOB _____

Signature _____Time_____Date_____

(Required for minor patients)

MedStar reserves the right to require legal proof of the requestor's status as Personal Representative of the patient (e.g., photo identification, guardianship papers, power of attorney document, etc.) MedStar Health also reserves the right to revoke access at any time. Any person granted proxy access (Personal Representative) may use the patient's health information **only** to access medical information and services on the patient's behalf via *my*MedStar on line and perform other functions provided by the portal. This authorization does NOT allow the Personal Representative to (1) make other health care decisions on the patient's behalf OR (2) access the patient's health information other than via *my*MedStar online.

This authorization shall be valid until terminated in writing by the parent, guardian, Personal Representative, or patient over the age of 18. Access will be automatically restricted to information allowed by regulation for Personal Representatives when a patient reaches the age of 13. When a patient reaches age 18, all access for Personal Representatives will be removed. Personal Representatives may then re-apply with approval of the patient.

Please Note: Messages are not blocked from proxy view.

***For non-emancipated patients 13 to 17**:
Approval is granted to the above patient to access their information and perform functions provided by the myMedStar Patient Portal. This includes but is not limited to access to diagnoses, test results, medications and treatments including mental health, drug/alcohol use, HIV, sexually transmitted diseases, pregnancy, family and social history and other selected documents. Patient may also email their care provider, request medication renewals, referrals and copies of their medical chart.

MedStar Health Use Only

Patient EMPI/MRN:_____ Department/Care Center_____

ID Verified By: _____ Physician Name: _____

ID Type provided:_____ Retain supporting documents in the patient's chart.

MedStar Health

Advance Directive

Your Durable Power of Attorney for Health Care, Living Will and Other Wishes

This document has been prepared and distributed as an informational service of the District of Columbia Hospital Association.

Instructions and Definitions

Introduction

This form is a combined durable power of attorney for health care and living will for use in D.C., Maryland and Virginia. With this form, you can:

- Appoint someone to make medical decisions for you if you, in the future, are unable to make those decisions for yourself.
- Indicate what medical treatment you do or do not want if, in the future, you are unable to make your wishes known.

Directions

- Read each section carefully.
- Talk to the person you plan to appoint to make sure that he/she understands your wishes and is willing to take the responsibility.
- Place the initials of your name in the blank before those choices you want to make.
- Fill in only those choices that you want under parts 1, 2 and 3. Your advance directive should be valid for whatever part(s) you fill in as long as it is properly signed.
- Add any special instructions in the blank spaces provided. You can write additional comments on a separate piece of paper but you should indicate on the form that there are additional pages to your advance directive.
- Sign the form and have it witnessed.
- Give to your family and anyone else who might be involved in your care a copy of your advance directive and discuss it with them.
- Understand that you may change or cancel this document at any time.

Words You Need to Know

- **Advance Directive**: A written document that tells what a person wants or does not want if he/she in the future can't make his/her wishes known about medical treatment.
- **Artificial Nutrition and Hydration**: When food and water are fed to a person through a tube.
- **Autopsy**: An examination done on a dead body to find the cause of death.
- **Comfort Care**: Care that helps to keep a person comfortable but does not make him/her better. Bathing, turning, and keeping a person's lips moist are types of comfort care.
- **CPR (Cardiopulmonary Resuscitation)**: Treatment to try to restart a persons breathing or heartbeat. CPR may be done by pushing on the chest, by putting a tube down the throat, or by other treatment.
- **Durable Power of Attorney for Health Care**: An advance directive that appoints someone to make medical decisions for a person if in the future he/she can't make his or her own medical decisions.
- **Life-Sustaining Treatment**: Any medical treatment that is used to keep a person from dying. A breathing
- machine, CPR and artificial nutrition and hydration are examples of life -sustaining treatments.
- **Living Will**: An advance directive that tells what medical treatment a person does or does not want if he/she is not able to make his/her wishes known.
- **Organ and Tissue Donation**: When a person permits his/her organs (such as eyes or kidneys) and other parts of the body (such as skin) to be removed after death to be transplanted for use by another person or to be used for experimental purposes.
- **Persistent Vegetative State**: When a person is unconscious with no hope of regaining consciousness even with medical treatment. The body may move and eyes may be open but as far as anyone can tell, the person can't think or respond.
- **Terminal Condition**: An ongoing condition caused by injury or illness that has no cure and from which doctors expect the person to die even with medical treatment. Life-sustaining treatments will only prolong a person's dying if the person is suffering from a terminal condition.

Maryland and Virginia

Advance Directive

Your Durable Power of Attorney for Health Care,
Living Will and Other Wishes

Patient Name:

DOB:

I,_____ write this document as a directive regarding my medical care.

Put the initials of your name by the choices you want.

Part 1. My Durable Power of Attorney for Health Care

____ I appoint this person to make decisions about my medical care if there ever comes a time when I cannot make those decisions myself:

Name _____

Phone: Home _____ Work/Mobile _____

Address _____

_____

If the person above can't or will not make decisions for me, I appoint this person:

Name _____

Phone: Home _____ Work/Mobile _____

Address _____

_____

____ I have not appointed anyone to make health care decisions for me in this or any other document.

I want the person I have appointed, my doctors, my family, and others to be guided by the decisions I have made below:

Part 2. My Living Will

These are my wishes for my future medical care if there ever comes a time when I can't make these decisions for myself.

A. These are my wishes if I have a terminal condition:

Life-Sustaining Treatments

____ I do not want life-sustaining treatments (including CPR) started. If life-sustaining treatments are started, I want them stopped.

____ I want life-sustaining treatments that my doctors think are best for me.

____ Other wishes: _____

Artificial Nutrition and Hydration

____ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.

____ I want artificial nutrition and hydration even if it is the main treatment keeping me alive.

____ Other wishes: _____

Comfort Care

____ I want to be kept as comfortable and free of pain as possible, even if such care prolongs my dying or shortens my life.

____ Other wishes: _____

B. These are my wishes if I am ever in a persistent vegetative state:

Life-Sustaining Treatments

____ I do not want life-sustaining treatments (including CPR) started. If life- sustaining treatments are started, I want them stopped.

____ I want life-sustaining treatments that my doctors think are best for me.

____ Other wishes: _____

Artificial Nutrition and Hydration

____ I do not want artificial nutrition and hydration started if it would be the main treatment keeping me alive. If artificial nutrition and hydration is started, I want it stopped.

____ I want artificial nutrition and hydration even if it is the main treatment keeping me alive.

____ Other wishes: _____

Comfort Care

____ I want to be kept as comfortable and free of pain as possible even if such care prolongs my dying or shortens my life.

____ Other wishes: _____

C. Other Directions

You have the right to be involved in all decisions about your medical care, even those not dealing with terminal conditions or persistent vegetative states. If you have wishes not covered in other parts of this document, please indicate them here:

_____

_____

Part 3. Other Wishes

A. Organ Donation

____ I do not wish to donate any of my organs or tissues.

____ I want to donate all of my organs and tissues.

____ I only want to donate these organs and tissues: _____

____ Other wishes: _____

B. Autopsy

____ I do not want any autopsy.

____ I agree to an autopsy if my doctors wish it.

____ Other wishes: _____

If you wish to say more about any of the above choices, or if you have any other statements to make about your medical care, you may do so on a separate sheet of paper. If you do so, put here the number of pages you are adding: _____

Part 4. Signature

You and two witnesses must sign this document for it to be legal.

Instructions to Witnesses

The person named as the health care agent may not sign as a witness. Any other competent person over age 18, including an employee of a health care facility or a physician caring for the individual making this appointment, if acting in good faith, may be a witness.

At least one witness must be a person who is not knowingly entitled to any portion of the estate of the individual making this Advance Directive or knowingly entitled to any financial benefit by reason of the death of the individual making this Advance Directive.

A. Your Signature

By my signature below, I show that I understand the purpose and the effect of this document.

Name _____ Date _____

Address _____

B. Your Witnesses' Signature

The individual making this Advance Directive signed or acknowledged signing this Advance Directive in my presence. Based upon my personal observation, this individual appears to be competent.

Witness #1

Name _____ Date _____

Address _____

Witness #2

Name _____ Date _____

Address _____