Central Illinois Endoscopy Center

Upper Endoscopy (EGD) Informed Consent Form

I _____ DOB: _____ do hereby authorize _____, MD, and any assistant(s) he/she may designate to perform upon me the procedure of: EGD WITH POSSIBLE BIOPSY AND/OR POLYPECTOMY AND/OR DILATION AND/OR PEG PLACEMENT (EGD/PEG) with the accompanying moderate sedation/analgesia as necessary.

1. I understand that this is a procedure performed to examine the inside of my esophagus, stomach and duodenum. The examination uses a long flexible, fiberoptic lighted tube that allows for viewing inside of these organs. The physician inserts the fiberoptic tube into your mouth and moves it into your gastrointestinal tract. This procedure requires intravenous sedative and local anesthetic to help you relax.
2. I understand that this procedure is generally safe, but certain risks accompany any endoscopic procedure. The risks of an Upper Endoscopy include, but are not limited to the following:
    - Perforation (a hole is created in the lining of the esophagus, stomach, or duodenum) this may require surgery to repair. The risk is increased when there is a biopsy taken, a polyp removed, or the esophagus dilated.
    - Bleeding. The risk is increased when there is a biopsy taken or a polyp removed. This is usually minor and can usually be stopped through the endoscope. Rarely, surgery is needed to stop the bleeding.
    - Reactions to IV sedative drugs/topical anesthetic spray including but not limited to rash, low blood pressure, breathing difficulty, irritation of the skin, and impaired oxygen delivery.
    - A small possibility that you cannot be completely sedated and therefore may experience some pain and discomfort during the procedure.
    - Rare, unusual reactions, including possible death, following any endoscopic procedure.
    - Infection.
    - Broken teeth.
3. I understand that the practice of medicine is not an exact science, and that no guarantee can be made regarding the outcome of my planned procedure.
4. I understand that an Upper GI barium x-ray is an alternative to this procedure.
5. I understand/that if any immediate life-threatening events happen during the procedure, they will be treated accordingly.
6. I understand that an Upper Endoscopy is not completely accurate and occasionally abnormalities, including cancer may be missed.
7. A resident (doctor still in training) may participate in my procedure, as well as the extent of the resident's participation and I have agreed to the resident's participation. I understand that I may refuse to be involved in the formal training of medical and other students without this affecting my care and treatment in a negative way.
8. I consent to the entering of authorized personnel and observers including students to the procedure room.
9. I consent to the photographing, videotaping, audio or other digital recordings, or televising of the operations or procedures to be performed including necessary portions of my body for medical, scientific or educational purposes. I understand that my identity will not be revealed by the pictures or by writings that accompany them and I have the right to request the stopping of any recording or filming. I consent to the pictures or by writings that accompany them and I have the right to request the stopping of any recording or filming.
10. **I CERTIFY THAT I HAVE READ OR HAD READ TO ME THE CONTENTS OF THIS FORM. I UNDERSTAND THE RISKS, SIDE EFFECTS AND ALTERNATIVES INVOLVED IN THIS PROCEDURE. I HAVE HAD THE OPPORTUNITY TO ASK ANY QUESTIONS WHICH I HAD AND ALL OF MY QUESTIONS WERE ANSWERED.**

_____ Date: _____ Time: _____

(Signed by patient or patient legally authorized to consent for patient)

Date _____Time _____ Signature of witness_____Print Name_____

PHYSICIAN DECLARATION: I have explained the contents of this document to the patient and have answered all the Patients/authorized Representative questions. To the best of my knowledge, I feel the patient has been adequately Informed and has consented.

_____ _____

Physician's Signature Date/Time

Central Illinois Endoscopy Center

PHYSICIAN OWNERSHIP DISCLOSURE FORM

In accordance with Federal ASC Regulations (42 C.F.R. 416.50(a)(ii)), the following ownership disclosure is made in advance of the date of the procedure:

Central Illinois Endoscopy Center is owned in part by the physicians of Illinois Gastroenterology Institute. The physician who will be performing your procedure is an owner of that practice.

You have the option to be treated at another health care facility such as OSF Saint Francis Medical Center, Unity Point - Methodist, or Unity Point - Proctor.

Central Illinois Endoscopy Center

FINANCIAL AGREEMENT Patient Name: _____

Medically Insured Patient:

As a courtesy to our patients we will bill your insurance company. Please make sure all of your information is correct and up to date with us. Your insurance cards need to be presented at the time of your visit. If we are not provided with the correct information, you will be billed and are responsible for the services rendered.

Provider Coverage:

The endoscopy center will pre-certify your procedure to ensure that our facility is covered but pre-certification is not a guaranty of payment. It is the patient's responsibility to know the specific terms and provisions of the coverage provided in the insurance policy. If your insurance denies the claim due to plan provisions or for any reason, you will be responsible for the balance.

Payment Methods:

- **We accept cash, check, MasterCard, Visa, or Discover.**
- **Self-pay procedures must be paid in full on or before the day the services are performed other than pathology which will be billed if those services are utilized.**
- **Payment Plans can be set up if necessary with no interest charged**
- **Accounts past due may be assigned to TH Professional and Medical Collections for additional collection activity.**

All no-shows and late cancellations (cancels within 24 hours) will be billed $95. To avoid this charges please notify us within 24hrs.

Please provide CIEC with a contact number you would like your messages left on. If you prefer that a message not be left on a voice mail please specify below. By signing you authorize CIEC to leave a message on the phone number provided.

HIPPA: By signing below I acknowledge that I have been given access to the center's Notice of Privacy Practice.
I hereby authorize CIEC to furnish information to the insurance carrier(s) concerning my illness and/or treatments as required for the processing of medical benefits.

Assignment and COLLECTION FEES: I hereby assign CIEC all payments for medical services rendered to my dependent(s) or myself. I understand that this authorization will remain in effect for as long as my dependent(s) or I remain a patient. I understand that I am financially responsible to CIEC for the charges not covered by this assignment. In the event that I default on payment of my charges, I understand that I am also responsible for any costs incurred in the collection process. If this account is sent to collections, the fees are typically 30 to 50% of my bill, plus court costs and attorney fees, and this charge will be added to my balance due. A photocopy of this agreement shall be as valid as the original.

Central Illinois Endoscopy strives to provide the best possible care to our patients. Your understanding of our financial procedures is important to our relationship. If you are unclear of your financial responsibilities or our Financial Policies please feel free to contact our billing department at (309) 495-1149.

I acknowledge that I have read and agree with the above Financial Policy. I recognize that I am ultimately responsible for the timely payment of my account.

Signature: _____ Date: _____

Phone number: _____ ALT Number: _____

Witness: _____ Date: _____

Central Illinois Endoscopy Center

Notice of Privacy Practices for Protected Health Information

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Understanding Your Health Record/Information

Each time you visit a Central Illinois Endoscopy Center (CIEC), a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- basis for planning your care and treatment
- means of communication among the many health professionals who contribute to your care
- legal document describing the care you received
- means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of information for public health officials charged with improving the health of the nation
- a tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record enables you to ensure its accuracy. Understanding how your health information is used helps you to better understand who, what, when, where, and why others may access your health information and make more informed decisions when authorizing disclosure to others. By reading this notice and signing the acknowledgement form, you are allowing CIEC to use, access and disclose your health information for treatment, payment, and health operations.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- obtain a paper copy of the notice of information practices upon request
- inspect and copy your health record
- request an amendment to your health record
- obtain an accounting of disclosures of your health information
- request communication of your health information by alternative means or to an alternative location
- revoke your authorization to use or disclose health information except to the extent that action has already been taken
- request a restriction on certain uses and disclosures of your information

Our Responsibilities

This organization is required to:

- maintain the privacy of your health information
- provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction
- accommodate reasonable requests you may have to communicate health information by alternative means or to an alternative location
- Protect privacy about a deceased individual as long as the information is maintained

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide a revised notice during registration at your next visit. We will not use or disclose your health information without your authorization, except as described in this notice.

Confidentiality of information

Violation of the federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected abuse or neglect (of a child or an adult) from being reported under state law to appropriate state or local authorities.

For More Information or to Report a Problem

The CIEC contact person for all issues regarding patient privacy and your rights under the federal privacy standards is the Privacy Officer. Information regarding matters covered by this Notice can be requested by contacting the Privacy Officer. If you feel that your privacy rights have been violated by this facility you may submit a complaint to our Privacy Officer by sending it to:

ATTN: Privacy Officer
CIEC
1001 Main Street, Suite 500B
Peoria, IL , 61606

The Privacy Officer can be contacted by telephone at 309/495-1148.

Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment. For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that would work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. We may contact you to provide appointment reminders or treatment alternatives.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations. For example: Members of the medical staff or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide. Patient satisfaction surveys are used to determine how satisfied you are with our service. This survey may be in the form of a telephone call or a written survey.

Uses or Disclosures CIEC may make without your Authorization

Business associates: There are some services provided in our organization through contacts with business associates. Examples include a copy service we use when making copies of your health record or a billing service. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Minors: We will follow Illinois State Law as it relates to 'personal representatives' or non-emancipated minors.

Research: We may disclose information to researchers when there are established research protocols or where we have obtained a waiver from an institutional review board.

Limited Data Set: We may use or disclose a limited data set (i.e. in which certain identifying information has been removed) of your protected health information for purpose of research, public health, or health care operations. Any recipient of that limited data set must agree to appropriately safeguard your information.

Incidental Uses and Disclosures: We are permitted to use and disclose information incidental to another use or disclosure of your protected health information permitted or required under law.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We do not provide patient information to other organizations.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Your Right to Inspect and Copy: You generally have the right to inspect and obtain a copy of any protected health information in your medical record, information compiled in anticipation of use in a civil, criminal or administrative proceeding and certain other health information which the law restricts CIEC from disseminating.

Federal law makes provisions for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Examples of Disclosures by Illinois State Law that require specific Patient Authorization

In general, release of medical records is restricted except where Federal or State Law allows. The following Medical Records disclosures require your written permission:

- Patients with high blood pressure to the Illinois High Blood Pressure Registry.
- Patients of an Advanced Practical Nurse to the Advanced Practice Nursing Board/Department of Professional Regulation
- Patients of a podiatrist to the Podiatric Medical Licensing Board.
- Patients of an impaired Physician (physical or mental) to the Medical Disciplinary Board.
- Patients who receive genetic testing may have results released to you and to person you designate in writing to receive the information. In the case of minors under 18 years of age, parents/legal guardians maybe notified with written permission except where allowed by law.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

CIEC reserves the right to change the terms of its privacy notice and to make the new provisions effective for all protected health information that CIEC maintains.

Central Illinois
Endoscopy Center

PATIENT RIGHTS AND RESPONSIBILITIES

POLICY

Central Illinois Endoscopy Center believes that health care is a cooperative effort between you as the patient, your physician, and our employees. You are a key member of the treatment team. Recognizing that patients have rights, we have listed below the things you may expect and in turn your responsibilities while a patient at Central Illinois Endoscopy Center.

Central Illinois Endoscopy and medical staff have adopted the following statement of patient rights. These rights are explained to the patient or the patient's representative (as allowed under state law). These rights shall include, but not be limited to, the patient's right to:

PATIENT RIGHTS

1. You have the right to considerate and respectful care with dignity and without discrimination, abuse, harassment or reprisal.
2. You have the right to be involved in your plan of care and treatment.
3. You have the right to obtain from your physician complete current information concerning diagnosis, treatment, and prognosis in terms you can be reasonably expected to understand. When it is not medically advisable to give such information to you, the information should be made available to an appropriate person on your behalf.
4. You have the right to receive from your physician information necessary to give informed consent prior to the start of procedures and/or treatments involving substantial risks. Except in emergencies, such information for informed consent should include but not necessarily be limited to specific procedures and/or treatments and the medically significant risks involved. Where medically significant alternatives for care or treatment exist, or when you request information concerning medical alternatives, you have the right to such information.
5. You have the right to know the name of the person responsible for performing your procedures and/or treatments
6. You have the right to refuse treatment and to be informed of the medical consequences of your action.
7. You have the right to prepare and submit an advance directive, such as a living will, and to choose someone to make decisions for you in case you cannot do so yourself. You may change your mind about health care decisions at any time.
8. You have the right to every consideration of your privacy concerning your own medical care program. Case discussion, consultation, examination, and treatment are confidential and should be conducted discreetly.
9. You have the right to expect that all communications and records pertaining to your care be treated as confidential except as otherwise provided by law or contractual agreements.
10. You have the right to access information contained in your records, as allowed by policy and by law.
11. You have the right to expect that within its capacity, the physicians and staff will make reasonable response to your request for services. When medically indicated, you may be transferred to another physicians office only after you have received complete information and explanation concerning the needs for and alternatives to such a transfer.
12. You have the right to expect reasonable continuity of care. You have the right to expect your physician or a delegate of your physician to inform you of your continuing health-care requirements following discharge.
13. You have the right to examine and receive an explanation of your bill, regardless of source of payment, and you shall be informed of services for which your insurance policy does not provide coverage.
14. It is Illinois Gastroenterology Institute's goal and commitment to provide a safe and secure environment for all our patients, visitors and employees.
15. If you need to communicate problems or issues concerning your medical care, please contact the facility manager.
16. You have the right to change your GI physician if another GI physician is available and agrees to the change.
17. You have the right to refuse to participate in experimental research.

PATIENT RESPONSIBILITIES

1. Your physician expects that you or your family will provide complete and accurate information to the best of your ability about your health, any medications including over-the-counter products and dietary supplements and any allergies or sensitivities.
2. In order to facilitate your care and the efforts of your physician and the office employees in their efforts to provide care, you are expected to follow their instructions and medical orders.
3. Duly authorized members of your family are expected to be available to office personnel for review of your treatment in the event you are unable to properly communicate with the physicians or nurses.
4. The office expects that you will cooperate with all personnel and ask questions if directions and/or procedures are not clearly understood.
5. You are expected to be considerate of other patients and office personnel and to assist in the control of noise, smoking, and the number of visitors with you at any one time. You are also expected to be respectful of the property of other persons and the property of the office.
6. It is expected that you will not take drugs which have not been prescribed by your attending physician and administered by office employees and that you will not consume any alcoholic beverages or toxic substances not allowed by your physician during your stay or after your stay as prescribed by your physician.
7. You are expected to observe all safety regulations that you have been made aware of by both verbal and other means.
8. You are responsible to inform the office about any living will, medical power of attorney, or other directive that could affect your care.
9. You are financially responsible for any charges not covered by your insurance.

COMPLAINT/GRIEVANCE PROCEDURE. YOU/YOUR REPRESENTATIVE'S RIGHTS INCLUDE

1. Discussion of any concerns/dissatisfaction with the care received, which cannot be resolved by available staff, by contacting the Practice Administrator at (309) 672-4980 or ask any staff member to contact them on your behalf.
2. You may also contact the Illinois Department of Public Health 24-hour hotline, 1-800-252-4343 or Illinois Department of Public Health, Office of Health Care Regulation, 525 W. Jefferson Street, 5th Floor, Springfield, IL 62761-0001 or www.medicare.gov/navigation/nelp-and-support/ombudsman.aspx.

REFERENCE: CMS Conditions of Participation 482.13

Central Illinois Endoscopy Center

Information for your driver

To make your short stay with us go even smoother please give this informational sheet to you driver prior to your visit.

After arriving with the patient *DO NOT LEAVE* the Illinois Medical Center premises. Many time doctors and staff may have questions or instructions that the sedated patient is unable to answer.

- The length of stay for most patients is about 2 hours. Some patients are here longer because of more involved procedures. As the driver you will be called to the recovery area to sit with the patient while they recover about 90 minutes after the start of the procedure.
- Feel free to use the vending machine on level 1 of the building for snacks and soft drink items. Just remember the Endoscopy Center waiting area is on level 5 of the building.
- Feel free to help yourself to coffee in the waiting room.
- Free computer wi-fi, cable television and magazines are available in the waiting area. If you have difficulties connecting to the wi-fi please let the staff know and they will find assistance.
- It is common for patients not to remember much of the conversation with the physicians in recovery. Please take the time to go through the information with them.

Directions to Central Illinois Endoscopy Center are on the back of this page.

Central Illinois Endoscopy Center

Illinois Medical Center
1001 Main Street, Peoria IL 61606

Located on the corner of Main Street and U of I Medical Way (near the Unity Point – Methodist Complex across from Methodist Atrium)

- **Directions from the East Peoria/Morton area:** Merge onto I-74W. Take the IL-29/US-24/Adams St. exit, EXIT 93, toward Jefferson Ave/Downtown Peoria. Merge onto Spalding Ave/Il-29. Take the 1st left onto NE Jefferson/US-24W/IL-29. Continue to follow NE Jefferson Ave. Turn right onto Main St. 1001 Main Street is on the left.

- **Directions from the Peoria/Galesburg area:** Merge onto I-74E. Take EXIT 92B toward IL-40 S/Glen Oak Ave/Downtown Peoria. Merge onto N Knoxville Ave. Stay straight to go onto Fayette St. Turn slight right on NE Glendale Ave. Take the 2nd right onto Main St. 1001 Main St. is on the left. (Your destination is just past U of I Medical Way. If you reach NE Crescent Ave., you've gone too far).

- **From the U of I Medical Way:** take a quick right onto the ramp leading into the parking lot. **We are located on the 5th floor of the IMC Building.**

STATEMENT OF ILLINOIS LAW ON ADVANCE DIRECTIVES AND DNR ORDERS

You have the right to make decisions about the health care you get now and in the future. An advance directive is a written statement you prepare about how you want your medical decisions to be made in the future, if you are no longer able to make them for yourself. A do not resuscitate order (DNR order) is a medical treatment order that says cardiopulmonary resuscitation (CPR) will not be used if your heart and/or breathing stops.

Federal law requires that you be told of your right to make an advance directive when you are admitted to a health-care facility. Illinois law allows for the following three types of advance directives: (1) health care power of attorney; (2) living will; and (3) mental health treatment preference declaration. In addition, you can ask your physician to work with you to prepare a DNR order. You may choose to discuss with your health-care professional and/or attorney these different types of advance directives as well as a DNR order. After reviewing information regarding advance directives and a DNR order, you may decide to make more than one. For example, you could make a health care power of attorney and a living will.

If you have one or more advance directives and/or a DNR order, tell your health-care professional and provide them with a copy. You may also want to provide a copy to family members, and you should provide a copy to those you appoint to make these decisions for you.

State law requires copies of sample advance directive forms. In addition, this webpage provides a copy of these forms and a copy of the Illinois Department of Public Health (IDPH) Uniform Do Not Resuscitate (DNR) Advance Directive.

Health Care Power of Attorney

The health care power of attorney lets you choose someone to make health-care decisions for you in the future, if you are no longer able to make these decisions for yourself. You are called the "principal" in the power of attorney form and the person you choose to make decisions is called your "agent." Your agent would make health-care decisions for you if you were no longer able to make these decisions for yourself. So long as you are able to make these decisions, you will have the power to do so. You may use a standard health care power of attorney form or write your own. You may give your agent specific directions about the health care you do or do not want.

The agent you choose cannot be your health-care professional or other health-care provider. You should have someone who is not your agent witness you signing the power of attorney.

The power of your agent to make health-care decisions on your behalf is broad. Your agent would be required to follow any specific instructions you give regarding care you want provided or withheld. For example, you can say whether you want all life-sustaining treatments provided in all events; whether and when you want life-sustaining treatment ended; instruments regarding refusal of certain types of treatments on religious or other person grounds; and instructions regarding anatomical gifts and disposal of remains. Unless you include time limits, the health care power of attorney will continue in effect from the time it is signed until your death. You can cancel your power of attorney at any time, either by telling someone or by canceling it in writing. You can name a backup agent to act if the first one cannot or will not take action. If you want to change your power of attorney, you must do so in writing.

Living Will

A living will tells your health-care professional whether you want death-delaying procedures used if you have a terminal condition and are unable to state your wishes. A living will, unlike a health care power of attorney, only applies if you have a terminal condition. A terminal condition means an incurable and irreversible condition such that death is imminent and the application of any death delaying procedures serves only to prolong the dying process.

Even if you sign a living will, food and water cannot be withdrawn if it would be the only cause of death. Also, if you are pregnant and your health-care professional thinks you could have a live birth, your living will cannot go into effect.

You can use a standard living will form or write your own. You may write specific directions about the death-delaying procedures you do or do not want.

Two people must witness your signing of the living will. Your health-care professional cannot be a witness. It is your responsibility to tell your health-care professional if you have a living will if you are able to do so. You can cancel your living will at any time, either by telling someone or by canceling it in writing.

If you have both a health care power of attorney and a living will, the agent you name in your power of attorney will make your health care decisions unless he or she is unavailable.

Do-Not-Resuscitate Order

You may also ask your health care professional about a do-not-resuscitate order (DNR order). A DNR order is a medical treatment order stating that cardiopulmonary resuscitation (CPR) will not be attempted if your heart and/or breathing stops. The law authorizing the development of the form specifies that an individual (or his or her authorized legal representative) may execute the IDPH Uniform DNR Advance Directive directing that resuscitation efforts shall not be attempted. Therefore, a DNR order completed on the IDPH Uniform DNR Advance Directive contains an advance directive made by an individual (or legal representative), and also contains a physician's order that requires a physician's signature.

Before a DNR order may be entered into your medical record, either you or another person (your legal guardian, health care power of attorney or surrogate decision maker) must consent to the DNR order. This consent must be witnessed by two people who are 18 years or older. If a DNR order is entered into your medical record, appropriate medical treatment other than CPR will be given to you. This webpage provides a link to guidance for individuals, health-care professionals and health-care providers concerning the IDPH Uniform DNR Advance Directive.

What happens if you don't have an advance directive:

Under Illinois law, a health care "surrogate" may be chosen for you if you cannot make health-care decisions for yourself and do not have an advance directive. A health care surrogate will be one of the following persons (in order of priority): guardian of the person, spouse, and adult child(ren), either parent, and adult brother or sister, any adult grandchild(ren), a close friend, or guardian of the estate.

The surrogate can make all health-care decisions for you, with certain exceptions. A health care surrogate cannot tell your health-care professional to withdraw or withhold life-sustaining treatment unless you have a "qualifying condition", which is a terminal condition, permanent unconsciousness, or an incurable or irreversible condition. A "terminal condition" is an incurable or irreversible injury for which there is no reasonable prospect of cure or recovery, death is imminent and life-sustaining treatment will only prolong the dying process. "Permanent unconsciousness" means a condition that, to a high degree of medical certainty, will last permanently, without improvement; there is no thought, purposeful social interaction or sensory awareness present; and providing life-sustaining treatment will only have minimal medical benefit. An "incurable or irreversible condition" means-an illness or injury for which there is no reasonable prospect for cure or recovery, that ultimately will cause the patient's death, that imposes severe pain or an inhumane burden on the patient, and for which life-sustaining treatment will have minimal medical benefit.

Two doctors must certify that you cannot make decisions and have a qualifying condition in order to withdraw or withhold life-sustaining treatment. If your health care surrogate decision maker decides to withdraw or withhold life-sustaining treatment, this decision must be witnessed by a person who is 18 years or older. A health care surrogate may consent to a DNR order, however, this consent must be witnessed by two individuals 18 years or older.

A health care surrogate, other than a court-appointed guardian, cannot consent to certain mental health treatments, including treatment by electroconvulsive therapy (ECT), psychotropic medication or admission to a mental health facility. A health care surrogate can petition a court to allow these mental health services.

Final Notes

You should talk with your family, your health-care professional, your attorney, and any agent or attorney-in-fact that you appoint about your decision to make one or more advance directives or a DNR order. If they know what health care you want, they will find it easier to follow your wishes. If you cancel or change an advance directive or a DNR order in the future, remember to tell these same people about the change or cancellation.

No health-care facility, health-care professional or insurer can make you execute an advance directive or DNR Order as a condition of providing treatment or insurance. It is entirely your decision. If a health-care facility, health-care professional or insurer objects to following your advance directive or DNR order then they must tell you or the individual responsible for making your health-care decisions. They must continue to provide care until you or your decision maker can transfer you to another health-care provider who will follow your advance directive or DNR order.