OREGON ADVANCE DIRECTIVE

furnished by

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The Advance Directive is used to appoint a representative to make health care decisions for you when you are unable to communicate, and to give guidance about medical and other care you want to receive at the end of your life. This Advance Directive also gives you the opportunity to explain how you want to be treated by your friends, family, and medical providers during the dying process.

You will find the Advance Directive to be thought provoking. Please consider each of your decisions carefully as you complete it. ***I highly recommend that you study the entire document before you record any decisions.***

After you have completed and signed your advance directive before two witnesses, you must be sure that the persons you have appointed as your representatives to make health care decisions for you also sign the directive, at the bottom of the final page. Your primary representative for health care decisions should retain the original Advance Directive. You may want to provide copies to your physicians, your alternate representative for health care decisions, family members, and to anyone else who needs to know your wishes.

To increase the likelihood that your wishes will be respected if you become incapacitated while you are away from home, you should also complete the wallet card on the final page, have it laminated, and carry it with you.

I wish to thank The Commission on Aging with Dignity, Tallahassee, Florida, which is the author of most of Part C, Section 6, for its permission to include its copyrighted material in this Advance Directive.

OREGON ADVANCE DIRECTIVE

(You Do Not Have to Fill out and Sign this Form)

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

This is an important legal document. It can control critical decisions about your health care. Before signing, consider these important facts:

Facts About Part B (Appointing a Health Care Representative)

You have the right to name a person to direct your health care when you cannot do so. This person is called your "health care representative." You can do this by using Part B of this form. Your representative must accept on Part E of this form.

You can write in this document any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts About Part C (Giving Health Care Instructions)

You also have the right to give instructions for health care providers to follow if you become unable to direct your care. You can do this by using Part C of this form.

Facts About Completing this Form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this advance directive, it will not expire. If you have set an expiration date, and you become unable to direct your health care before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation. Despite this document, you have the right to decide your own health care as long as you are able to do so. If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes or add words that better express your wishes. Witnesses must sign PART D.

Print your NAME, BIRTH DATE AND ADDRESS here:

____
(Name)

____
(Birth Date)

____
(Address)

____
(City, State, Zip)

Unless revoked or suspended, this advance directive will continue for:

INITIAL ONE:

________ My entire life

________ Other period (_____ Years)

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator or employee of your health care facility, unless that person is related to you by blood, marriage or adoption or that person was appointed before your admission into the health care facility.

I appoint ____ as my health care representative. My representative's address is: ____

____

and telephone number is ____.

I appoint ____ as my alternate health care representative.

My alternate's address is: ____

____

and telephone number is ____.

I authorize my representative (or alternate) to direct my health care when I can't do so.

1. Limits.

Special Conditions or Instructions: My representative is to honor my wishes expressed in Part C and the following instructions:

____

____

INITIAL IF THIS APPLIES:

______ I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

2. Life Support.

"Life support" refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

INITIAL IF THIS APPLIES:

_______ My representative MAY decide about life support for me. (If you don't initial this space, then your representative MAY NOT decide about life support.)

3. Tube Feeding.

One sort of life support is food and water supplied artificially by medical device, known as tube feeding. INITIAL IF THIS APPLIES:

_______ My representative MAY decide about tube feeding for me. (If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

____
(Signature of person making appointment)

Date Signed:____

PART C: HEALTH CARE INSTRUCTIONS

NOTE: In filling out these instructions, keep the following in mind:

The term “as my physician recommends” means that you want your physician to try life support if your physician believes it could be helpful and then discontinue it if it is not helping your health condition or symptoms.
“Life support” and “tube feeding” are defined in Part B above.
If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.
You will get care for your comfort and cleanliness, no matter what choices you make.
You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

1. Close to Death. If I am close to death and life support would only postpone the moment of my death:

A. INITIAL ONE:

_________ I WANT to receive tube feeding.

_________ I want tube feeding ONLY AS MY PHYSICIAN RECOMMENDS.

_________ I DO NOT WANT tube feeding.

B. INITIAL ONE:

_________ I WANT any other life support that may apply.

_________ I want life support ONLY AS MY PHYSICIAN RECOMMENDS.

_________ I want NO life support.

2. Permanently Unconscious. If I am unconscious and it is very unlikely that I will ever become conscious again:

A. INITIAL ONE:

_________ I WANT to receive tube feeding.

_________ I want tube feeding ONLY AS MY PHYSICIAN RECOMMENDS.

_________ I DO NOT WANT tube feeding.

B. INITIAL ONE:

_________ I WANT any other life support that may apply.

_________ I want life support ONLY AS MY PHYSICIAN RECOMMENDS.

_________ I want NO life support.

3. Advanced Progressive Illness. If I have a progressive illness that will be fatal and is in an advanced stage, and I am consistently and permanently unable to communicate by any means, swallow food and water safely, care for myself and recognize my family and other people, and it is very unlikely that my condition will substantially improve:

A. INITIAL ONE:

_________ I WANT to receive tube feeding.

_________ I want tube feeding ONLY AS MY PHYSICIAN RECOMMENDS.

_________ I DO NOT WANT tube feeding.

B. INITIAL ONE:

_________ I WANT any other life support that may apply.

_________ I want life support ONLY AS MY PHYSICIAN RECOMMENDS.

_________ I want NO life support.

4. Extraordinary Suffering. If life support would not help my medical condition and would make me suffer permanent and severe pain:

A. INITIAL ONE:

_________ I WANT to receive tube feeding.

_________ I want tube feeding ONLY AS MY PHYSICIAN RECOMMENDS.

_________ I DO NOT WANT tube feeding.

B. INITIAL ONE:

_________ I WANT any other life support that may apply.

_________ I want life support ONLY AS MY PHYSICIAN RECOMMENDS.

_________ I want NO life support.

5. General Instruction. (NOTE: Initial this instruction **only** if **none** of the above instructions 1 through 4 applies)

INITIAL IF THIS APPLIES:

_________ I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

6. Additional Conditions or Instructions. (INITIAL ANY THAT YOU WISH TO APPLY)

Dignity

_________ I do not want my doctors or nurses to do anything or to omit to do anything *with the intention of taking my life.*

_________ I want to be treated with dignity near the end of my life as my wishes are followed. To be treated with dignity means that I would like people to do the things that follow when they can be done. I understand that my family, my doctors and other health care providers, my friends, and others may not be able to do the things, or are not required by law to do all the things that follow. I do not expect my wishes that follow to place new or added legal duties on my doctors or other health care providers. I also do not expect these wishes to excuse my doctor or other health care providers from giving me the proper care asked for by law.

Comfort Care

_________ I do not want to be in pain. I want my doctor to give me enough medicine to relieve my pain, even if that means that I will be drowsy or sleep more than I would otherwise.

_________ If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my caregivers to do whatever they can to help me.

_________ I want to have a cool, moist cloth put on my head if I have a fever.

_________ I want my lips and mouth kept moist to stop dryness.

_________ I want to have warm baths often. I want to be kept fresh and clean at all times.

__________ I want to be massaged with warm oils as often as I can be.

__________ I want to have my favorite music played when possible until my time of death.

__________ I want to have personal care like shaving, nail clipping, hair brushing, and teeth brushing, as long as they do not cause me pain or discomfort.

__________ I want to have religious readings and well loved poems read aloud when I am near death.

__________ If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean, and for them to be changed as soon as they can be if they have been soiled.

__________ I want to die in my home, if that can be done.

Pregnancy

__________ If I am known to be pregnant, I **do not** want life-sustaining treatment withheld or withdrawn if it is possible that the embryo/fetus will develop to the point of live birth with the continued application of life-sustaining treatment.

My Relationships With Family and Friend as My Death Approaches

__________ I wish to have people with me when possible. I want someone to be with me when it seems that death may come at any time.

__________ I wish to have my hand held and to be talked to when possible, even if I don't seem to respond to the voice or touch of others.

__________ I wish to have others by my side praying for me when possible.

__________ I wish to have the members of my church or synagogue told that I am sick and asked to pray for me and visit me.

__________ I wish to be cared for with kindness and cheerfulness, and not sadness.

__________ I wish to have pictures of my loved ones in my room, near my bed.

What I Want My Loved Ones to Know

__________ I want to have my family members and loved ones know that I love them.

__________ I want to be forgiven for the times I have hurt my family, friends, and others.

__________ I want my family members and friends to know that I forgive them for anything they have done to me during my life.

__________ I want my family members, loved ones, and friends to know that because of the faith I have, I do not fear death, but I believe it is a new beginning for me. (Additional comments) ____

____

_

__________ I want my family members to make peace with each other before my death, if they can.

__________ I want my family and friends to remember me as I was before I had a terminal illness. I want them to remember me that way after I die.

__________ I want my family and friends to look at my dying as a time of personal growth for them, as well as for me. This will help me live a meaningful life in my final days.

__________ I want my family and friends to get counseling if they have trouble with my death. I want memories of my life to give them joy, and not sorrow.

If anyone asks how I want to be remembered, please say the following:

____

____

____

The following person knows my funeral wishes: ____

If there is a memorial service of any kind, I want the service to include the following *(list music, songs, readings or any other specific requests you have):*

____

____

____

____

Other Instructions (including any wishes about donating body organs when you die)

____

____

____

7. <u>Other Documents.</u> A "health care power of attorney" is any document you may have signed to appoint a representative to make health care decisions for you.

INITIAL ONE:

__________ I have previously signed a health care power of attorney. I want it to remain in effect unless I appointed a health care representative after signing the health care power of attorney.

__________ I have a health care power of attorney, and I REVOKE IT.

__________ I DO NOT have a health care power of attorney.

SIGN HERE TO GIVE HEALTH CARE INSTRUCTIONS

____
(Signature of person giving instructions)

Date Signed:____

PART D: DECLARATION OF WITNESSES

NOTE: One witness must not be a relative (by blood, marriage or adoption) of the person signing this advance directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate or be employed at a health care facility where the person is a patient or resident.

We declare that the person signing this advance directive:

(a) Is personally known to us or has provided proof of identity;

(b) Signed or acknowledged that person's signature on this advance directive in our presence;

(c) Appears to be of sound mind and not under duress, fraud or undue influence;

(d) Has not appointed either of us as health care representative or alternative representative; and

(e) Is not a patient for whom either of us is attending physician.

Witnessed By:

____
(Signature of Witness)

____
(Printed Name of Witness)
Date Signed:____________________________________

____
(Signature of Witness)

____
(Printed Name of Witness)
Date Signed:____________________________________

PART E: ACCEPTANCE BY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document allows me to decide about that person's health care only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider if known to me.

____
(Signature of Health Care Representative)

____
(Printed Name of Health Care Representative)

Date Signed:____________________________________

____
(Signature of Alternate Health Care Representative)

____
(Printed Name of Alternate Health Care Representative)

Date Signed:____________________________________

WALLET CARD

You may wish to laminate this card and keep it in your wallet

MY ADVANCE HEALTHCARE DIRECTIVE

Name: ____________________________

I have completed an Oregon Advance Directive. Please consult it and/or my health care representative in case of an emergency. My health care representative is:

Name: ____________________ Tel __________

I have also given a copy of my Advance Directive to:
Name: ____________________ Tel__________