Louisiana Advance Health Care Directive

On this date of ____________________ , I, ______________________________ , do hereby sign, execute, and adopt the following as my Advance Health Care Directive. I direct any and all persons or entities involved with my health care in any manner that these decisions are my wishes and were adopted without duress or force and of my own free will.

I have placed my initials next to the sections of this Directive that I have adopted:

[ ] Living Will (Declaration)
[ ] Selection of Health Care Agent
[ ] Designation of Primary Physician
[ ] Organ Donation

Living Will (Declaration)

If at any time I should have an incurable injury, disease or illness, be in a continual profound comatose state with no reasonable chance of recovery, or am certified to be in a terminal and irreversible condition by two (2) physicians who have personally examined me, one (1) of whom shall be my attending physician, and the physicians have determined that my death will occur whether or not life-sustaining procedures are utilized and where the application of life-sustaining procedures would serve only to prolong artificially the dying process, I direct **(initial one only)**:

[ ] That all life-sustaining procedures, including nutrition and hydration, be withheld or withdrawn so that food and water will not be administered invasively.

[ ] That life-sustaining procedures, except nutrition and hydration, be withheld or withdrawn so that food and water can be administered invasively.

I further direct that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this declaration shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.

Selection of Health Care Agent

I authorize ____ (name), of ____ (address), to make all medical treatment decisions for me, including decisions to withhold or withdraw any form of life-sustaining procedure on my behalf should I be: (1) diagnosed as suffering from a terminal and irreversible condition, and (2) comatose, incompetent, or otherwise mentally or physically incapable of communication. I have discussed my desires concerning terminal care with my agent named previously, and I trust his or her judgment on my behalf. I understand that if I have not

filled in any name in this clause or if the agent I have chosen is unavailable or unwilling to act on my behalf, my living will declaration will nevertheless be given effect should the above-discussed circumstance arise.

Designation of Primary Physician

I designate the following physician as my primary physician: _________________________ (name)
____ (address)
____(phone).

OPTIONAL- DESIGNATION OF ALTERNATE PRIMARY PHYSICIAN: If the physician I have designated above is not willing, able, or reasonably available to act as my primary physician, I designate the following physician as my primary physician:
____ (name)
____ (address)
____(phone).

Organ Donation

In the event of my death, I have placed my initials next to the following part(s) of my body that I wish donated for the purposes **that I have initialed below:**

[ ] any organs or parts **OR**
[ ] eyes [ ] bone and connective tissue [ ] skin
[ ] heart [ ] kidney(s) [ ] liver
[ ] lung(s) [ ] pancreas [ ] other ___________

for the purposes of:

[ ] any purpose authorized by law **OR**
[ ] transplantation [ ] research [ ] therapy
[ ] medical education [ ] other limitations ____________________________

Signature

I sign this Advance Health Care Directive, consisting of the following sections, **which I have initialed below and have elected to adopt:**

[ ] Living Will (Declaration)
[ ] Selection of Health Care Agent
[ ] Designation of Primary Physician
[ ] Organ Donation

BY SIGNING HERE I INDICATE THAT I UNDERSTAND THE PURPOSE AND EFFECT OF THIS DOCUMENT.

Signature _______________________________ Date ____________________

City, Parish, and State of Residence ____

Notary Acknowledgment

State of ____________________
Parish of ____________________

On ____________________ , ______________________________ came before me personally and, under oath, stated that he or she is the person described in the above document and he or she signed the above document in my presence. I declare under penalty of perjury that the person whose name is subscribed to this instrument appears to be of sound mind and under no duress, fraud, or undue influence.

____
Notary Public
My commission expires ____________________

Witness Acknowledgment

The declarant is personally known to me and I believe him or her to be of sound mind and under no duress, fraud, or undue influence. I did not sign the declarant's signature above for or at the direction of the declarant and I am not appointed as the health care agent or attorney-in-fact herein. I am at least eighteen (18) years of age and I am not related to the declarant by blood, adoption, or marriage, entitled to any portion of the estate of the declarant according to the laws of intestate succession or under any will of declarant or codicil thereto, or directly financially responsible for declarant's medical care. I am not a health care provider of the declarant or an employee of the health facility in which the declarant is a patient.

Witness Signature ______________________________ Date ____________________

Printed Name of Witness __________________________

Second Witness Signature ______________________________ Date ___________________

Printed Name of Second Witness __________________________

Acceptance of Health Care Agent

I accept my appointment as Health Care Agent:

Signature ______________________________ Date ____________________