

Oklahoma 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
- Appointment of Health Care Agent (Health Care Proxy)
- Designation of Primary Physician
- Organ Donation

If I am incapable of making an informed decision regarding my health care, I direct my health care providers to follow my instructions below.

Living Will

I, being of sound mind and eighteen (18) years of age or older, willfully and voluntarily make known my desire, by my instructions to others through my living will, or by my appointment of a health care proxy, or both, that my life shall not be artificially-prolonged under the circumstances set forth below. I thus do hereby declare:

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Advance Directive Act, to follow my instructions as set forth below:

If I have a terminal condition, that is, an incurable and irreversible condition that even with the administration of life-sustaining treatment will, in the opinion of the attending physician and another physician, result in death within six (6) months: **(Initial one choice only).**

- I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.
- I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.
- I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.
- See my more specific instructions in paragraph (4) below.

(2) If I am persistently unconscious, that is, I have an irreversible condition, as determined by the attending physician and another physician, in which thought and awareness of self and environment are absent: **(Initial one choice only)**

] I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

] I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

] I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

] See my more specific instructions in paragraph (4) below.)

(3) If I have an end-stage condition, that is, a condition caused by injury, disease, or illness, which results in severe and permanent deterioration indicated by incompetency and complete physical dependency for which treatment of the irreversible condition would be medically ineffective: **(Initial one choice only)**

] I direct that my life not be extended by life-sustaining treatment, except that if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

] I direct that my life not be extended by life-sustaining treatment, including artificially administered nutrition and hydration.

] I direct that I be given life-sustaining treatment and, if I am unable to take food and water by mouth, I wish to receive artificially administered nutrition and hydration.

] See my more specific instructions in paragraph (4) below.

(4) OTHER. Here you may: (a) describe other conditions in which you would want life-sustaining treatment or artificially administered nutrition and hydration provided, withheld, or withdrawn, (b) give more specific instructions about your wishes concerning life-sustaining treatment or artificially administered nutrition and hydration if you have a terminal condition, are persistently unconscious, or have an end-stage condition, or (c) do both of these:

Appointment of Health Care Agent (Health Care Proxy)

If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers pursuant to the Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act to follow the instructions of _____ (name), of _____ (address), whom I appoint as my health care proxy. If my health care proxy is unable or unwilling to serve, I appoint _____ (name) as my alternate health care proxy with the same authority. My health care proxy is authorized to make whatever medical treatment decisions I could make if I were able, except that decisions regarding life-sustaining treatment and artificially administered nutrition and hydration can be made by my health care proxy or alternate health care proxy only as I have indicated in the foregoing sections.

If I fail to designate a health care proxy in this section, I am deliberately declining to designate a health care proxy.

NOTE: A physician or other health care provider who is furnished the original or a photocopy of the advance directive shall make it a part of the declarant's medical record and if unwilling to comply with the advance directive, shall promptly so advise the declarant. In the case of a qualified patient, the patient's health care proxy, in consultation with the attending physician, shall have the authority to make treatment decisions for the patient including the withholding or withdrawal of life-sustaining procedures if so indicated in the patient's advance directive. A person executing an advanced directive appointing a health care proxy who may not have an attending physician for reasons based on established religious beliefs or tenets may designate an individual other than the designated health care proxy, in lieu of an attending physician and other physician, to determine the lack of decisional capacity of the person. Such designation shall be specified and included as part of the advanced directive executed pursuant to the provisions of this section.

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**

<input type="checkbox"/> eyes	<input type="checkbox"/> bone and connective tissue	<input type="checkbox"/> skin
<input type="checkbox"/> heart	<input type="checkbox"/> kidney(s)	<input type="checkbox"/> liver
<input type="checkbox"/> lung(s)	<input type="checkbox"/> pancreas	<input type="checkbox"/> other _____

for the purposes of:

any purpose authorized by law **OR**

<input type="checkbox"/> transplantation	<input type="checkbox"/> research	<input type="checkbox"/> therapy
<input type="checkbox"/> medical education	<input type="checkbox"/> 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
- Appointment of Health Care Agent (Health Care Proxy)
- Designation of Primary Physician
- Organ Donation

- a. I understand that I must be eighteen (18) years of age or older to execute this form.
- b. I understand that my witnesses must be eighteen (18) years of age or older and shall not be related to me and shall not inherit from me.
- c. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, I will be provided with life-sustaining treatment and artificially administered hydration and nutrition unless I have, in my own words, specifically authorized that during a course of pregnancy, life-sustaining treatment and/or artificially administered hydration and/or nutrition shall be withheld or withdrawn.
- d. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to choose or refuse medical or surgical treatment including, but not limited to, the administration of life-sustaining procedures, and I accept the consequences of such choice or refusal.
- e. This advance directive shall be in effect until it is revoked.
- f. I understand that I may revoke this advance directive at any time.
- g. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.
- h. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.
- i. I understand that my physician(s) shall make all decisions based upon his or her best judgment applying with ordinary care and diligence the knowledge and skill that is possessed and used by members of the physician's profession in good standing engaged in the same field of practice at that time, measured by national standards.

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

Signature _____ Date _____

City, County, and State of Residence _____

Notary Acknowledgment

State of _____

County 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 (Health Care Proxy)

I accept my appointment as Health Care Agent (Health Care Proxy):

Signature _____ Date _____