Oregon 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 (Health Care Instructions)
[ ] Selection of Health Care Agent (Appointment of Health Care Representative)
[ ] Designation of Primary Physician
[ ] Organ Donation

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: YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM UNLESS YOU WANT TO.
LIVING WILL (HEALTH CARE INSTRUCTIONS): You have the right to give instructions for health care providers to follow if you become unable to direct your care.
APPOINTMENT OF 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 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.
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.

Unless revoked or suspended, this advance directive will continue for **(initial one)**:

[ ] My entire life
[ ] Other period (_____ years)

Living Will (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 below. 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 paragraphs (1) to (4) below, or you may use the general instruction provided by paragraph (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 DO want to receive tube feeding.
[ ] I want tube feeding ONLY as my physician recommends.
[ ] I do NOT want tube feeding.
(b) **(initial one):**
[ ] I DO 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 DO want to receive tube feeding.
[ ] I want tube feeding ONLY as my physician recommends.
[ ] I do NOT want tube feeding.
(b) **(initial one):**
[ ] I DO 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 DO want to receive tube feeding.
[ ] I want tube feeding ONLY as my physician recommends.
[ ] I do NOT want tube feeding.
(b) **(initial one)**:
[ ] I DO 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 DO want to receive tube feeding.
[ ] I want tube feeding ONLY as my physician recommends.
[ ] I do NOT want tube feeding.
(b) **(initial one):**
[ ] I DO 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 **(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 paragraphs (1) to (4) above.

(6) ADDITIONAL CONDITIONS OR INSTRUCTIONS
(insert description of what you want done):

(7) OTHER DOCUMENTS. 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 not previously signed a health care power of attorney and I am appointing a health care representative in this document.

[ ] I HAVE previously signed a health care power of attorney and I want it to remain in effect and I am not appointing a different health care representative in this document.

[ ] I have previously signed a health care power of attorney, and I REVOKE it and I am appointing a health care representative in this document.

[ ] I do NOT have a health care power of attorney and I am not appointing a health care representative in this document.

Selection of Health Care Agent
(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 _____ (name), of _____ (address), as my health care representative. I authorize my representative to direct my health care when I cannot do so.

OPTIONAL - DESIGNATION OF ALTERNATE AGENT: If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make a health care decision for me, I designate as my alternate agent

_____ (name of individual you choose as alternate agent)

_____ (address)

LIVING WILL IN EFFECT: **(Initial if this applies):**
[ ] I have executed a Living Will Health Care Instruction or Directive to Physicians. My representative is to honor it. (This includes any Living Will that is part of this document)

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)**: **(If you don't initial this space, then your representative may NOT decide about tube feeding.)**

[ ] My representative MAY decide about life support for me.

TUBE FEEDING. One sort of life support is food and water supplied artificially by medical device, known as tube feeding **(Initial if this applies)**: **(If you don't initial this space, then your representative may NOT decide about tube feeding.)**

[ ] My representative MAY decide about tube feeding for me.

LIMITS. Special Conditions or Instructions to my Health Care Agent:
(Insert any conditions or instructions):

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 (Health Care Instructions)
[ ] Selection of Health Care Agent (Appointment of Health Care Representative)
[ ] Designation of Primary Physician
[ ] Organ Donation

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 _____

Witness Signature _____ Date _____

Printed Name of Witness _____

Acceptance of Health Care Agent (Health Care Representative)

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

Signature _____ Date _____

I accept my appointment as Alternate Health Care Agent (Health Care Representative):

Signature _____ Date _____