# Oregon Advance Directive

from http://WWW.LLX.COM/AD.pdf

*Completion of this form is optional. You do not need to fill it out or sign it.*

## A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

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

1) **Regarding Appointing a Health Care Representative:**

You have the right to name a person to direct your health care when you are unable to direct care for yourself. This person is referred to as your *Health Care Representative*. You can designate a Health Care Representative by using Part C of this form. Your representative must accept your choice by completing Part D of this form.

You do not have to have this document remain as it is. You can write in any provisions or restrictions you choose about how your representative makes decisions for you. Your representative must follow your desires as stated in this document and those otherwise made known. If your specific desires are unknown, your representative must try to act in your best interest. Your representative may resign at any time. Your alternate representative may take the place of your representative if your representative cannot continue to represent you.

2) **Giving Health Care Instructions**:

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

3) **Facts About Completing This Form**

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

Unless you choose to set a specific duration for this advance directive, this form will remain in effect until you revoke it. If you have set a specific expiration date and you become unable to direct your health care before that date, this advance directive will remain in effect and will not expire until you are able to make those decisions again.

You may revoke this document at any time by notifying 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. Consult a lawyer to explain it if there is anything in this document that you do not understand.

You may sign PART B, PART C, or both parts. You may make changes to the form by crossing out words that do not express your wishes or add words that better express your wishes. Witnesses must sign PART D.



Initials: _____

Print your NAME, BIRTHDATE and ADDRESS here and INITIAL the bottom of each page of this form:

_____ _____

(Name) (Birthdate)

_____

_____

(Address)

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

INITIAL ONE:

____ My entire life

____ Other period ( ____Years )

____ Until (date:) _____.

## PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

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 representative) to direct my health care when I cannot do so.

*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.*

1. **Limits.**

Special Conditions or Instructions:



Initials: _____

INITIAL IF THIS APPLIES:

____ I have executed a Health Care 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.)

_____

(Date)

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE in PART B

_____

*( Signature of person making appointment with this form -*
*Your Health Care Representative accepts/signs on page 8 )*



Initials: _____

## PART C: HEALTH CARE INSTRUCTIONS

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

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



Initials: _____

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 likely 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.**

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.



Initials: _____

6. **Additional Conditions or Instructions**. (Insert description of what you want done or not 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 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.

_____

(Date)

SIGNING HERE GIVES INSTRUCTIONS IN PART C.

_____

(Signature)



Initials: _____

## PART D: DECLARATION OF WITNESSES

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 1) (Date)

_____

(Printed Name of Witness 1)

_____ _____

(Signature of Witness 2) (Date)

_____

(Printed Name of Witness 2)

*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.*



Initials: _____

## PART V: 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) (Date)

_____

(Printed name)

_____ _____

(Signature of Health Alternate Care Representative) (Date)

_____

(Printed name)



Initials: _____