

Advanced Directives

I, _____, write this health care directive to help my loved ones and health care providers carry out my wishes.

Durable Power of Attorney for Health Care

_____ I appoint the person listed below to make decisions about my medical care if there comes a time I am unable to do so myself due to an illness or an advanced dementia. I request this person, my health care providers and family be guided by the decisions I have made as part of this document.

Name: _____

Address: _____

Phone number: _____

Email: _____

If the person above cannot or will not make decisions for me, I appoint this person:

Name: _____

Address: _____

Phone number: _____

Email: _____

_____ I have not appointed anyone to make health care decisions for me.

Living Will

In the event my condition is deemed terminal I would like the following:

Definition of terminal includes (check what applies):

_____ Cancer diagnosis with less than _____ months to live

_____ Advanced dementia

_____ End stage congestive heart failure

_____ Other _____

_____ Other _____

These are my wishes

I do not want the following life sustaining treatments.

_____ Cardiopulmonary resuscitation

_____ Breathing tube

- Nasogastric tube
- Intravenous fluid therapy
- Intravenous antibiotics
- Oral antibiotics
- Blood or blood product transfusions
- Medicines to prolong life that do not aid in my comfort such as cholesterol medicine
- Artificial nutrition if it would be the main treatment to keep me alive
- If artificial treatment is started, I want it stopped
- Surgery
- Other _____

These are my wishes if I am in a persistent vegetative state.

I do not want the following life sustaining treatments.

- Cardiopulmonary resuscitation
- Breathing tube
- Nasogastric tube
- Intravenous fluid therapy
- Intravenous antibiotics
- Oral antibiotics
- Blood or blood product transfusions
- Medicines to prolong life that do not aid in my comfort such as cholesterol medicine
- Artificial nutrition if it would be the main treatment to keep me alive
- If artificial treatment is started, I want it stopped
- Surgery
- Other _____

Miscellaneous Directions

Many health care situations cannot be foreseen. This section allows health care wishes to be expressed that may be specific to a certain disease state that are not covered under a terminal state or persistent vegetative state.

Organ donation:

- I do not want to donate any of my organs or tissues.
- I want to donate all of my organs and tissues.

Signature: _____

Date: _____

Address: _____

Witness

I believe that the person who signed above to be in sound mind and this document was signed in my presence. This advanced directive was not filled out or signed under pressure, fraud or undue influence.

I meet no criteria listed below:

- Related to by marriage, blood or adoption to the person making out this advanced directive
- The person appointed in this advanced directive
- The health care provider or an employee of the health care provider responsible for the person in this advanced directive

Signature: _____

Date: _____

Address: _____

Signature: _____

Date: _____

Address: _____
