**DRAFT**

**PLAIN LANGUAGE VERSION**

**7/16/20**

**Oregon Advance Directive for Health Care**

This **Advance Directive form** allows you to:

* Share your goals and wishes for health care if you were not able to express them yourself.
* Name a person to make your health care decisions if you could not make them for yourself. This person is called your health care representative.

Be sure to discuss your Advance Directive and your wishes with your health care representative. This would allow them to make decisions that reflect your wishes.

**It is best to complete this entire form.**

* To appoint a health care representative, complete Sections 1, 2, 5, 6, and 7.

* To provide instructions, complete Sections 3 and 4.

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself. The person is called a health care representative. If you do not have an effective health care representative appointment and become too sick to speak for yourself, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635(2).

This form also allows you to express your values and beliefs with respect to health care decisions and your preferences for health care.

* If you have completed an advance directive in the past, this new advance directive will replace any older directive.
* You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.
* If your advance directive includes directions regarding the withdrawal of life support or tube feeding, you may revoke your advance directive at any time and in any manner that expresses your desire to revoke it.
* In all other cases, you may revoke your advance directive at any time and in any manner as long as you are capable of making medical decisions.

1. **ABOUT ME**  
     
   Name: Date of Birth:

Telephone Numbers: (Home) (Work) (Cell)

Address:

Email:

1. **MY HEALTH CARE REPRESENTATIVE.**

I choose the following person as my health care representative to make health care decisions for me if I can’t speak for myself.

Name: Relationship:

Telephone Numbers: (Home) (Work) (Cell)

Address:

Email:

I choose the following people to be my alternate health care representatives if my first choice is not available to make health care decisions for me or if I cancel the first health care representative’s appointment.

First alternate health care representative:

Name: Relationship:

Telephone Numbers: (Home) (Work) (Cell)

Address:

Email:

Second alternate health care representative:

Name: Relationship:

Telephone Numbers: (Home) (Work) (Cell)

Address:

Email:

1. **Information for My Health Care Representative**

This section is the place for you to express your wishes, values and goals for care. This provides guidance for your health care representative and your health care providers.

You can direct your care with the choices you make below. This is the case even if you do not choose a health care representative or if they cannot be reached.

1. There are three cases below. They will help you think about the kinds of life support decisions your health care representative could face. For each case, choose the one option that most closely fits your wishes.

* **Terminal Condition**

This is what I would want if I had an illness that could not be cured and my providers believed would result in my death within six months. This would be the case even if using treatments that sustain life.

Initial one option only.

\_\_\_\_\_\_\_ **I would want** doctors to attempt treatments to sustain life. These include CPR

and xxx.

\_\_\_\_\_\_\_ **I would want** to extend my life with artificial feeding and hydration such as a

feeding tube and IV fluids. **I would not want** doctors to attempt other treatments

to sustain life.

\_\_\_\_\_\_\_ **I would not want** doctors to attempt treatments to sustain life. I **would not**

**want** artificial feeding and hydration.

\_\_\_\_\_\_\_ **I would want** my health care representative to decide for me after talking

with my health care provider.

* **Advanced Illness**

This is what I would want if…

* I had an illness that were in an advanced stage.
* It would be unlikely that my condition would substantially improve.
* And I were not ever able to:
  + Communicate by any means
  + Swallow food and water safely
  + Care for myself
  + Recognize my family and other people.

Initial one option only.

\_\_\_\_\_\_\_ **I would want** doctors to attempt treatments that sustain life. These include

CPR and xxx.

\_\_\_\_\_\_\_ **I would want** to extend my life with artificial feeding and

hydration. **I would not want** doctors to attempt other treatments to sustain

life.

\_\_\_\_\_\_\_ **I would not want** doctors to attempt treatments to sustain life. I **would not**

**want** artificial feeding and hydration.

\_\_\_\_\_\_\_ **I would want** my health care representative to decide for me after talking

with my health care provider.

* **Permanently Unconscious**

This is what I would want if I were unconscious and it would be very unlikely that I would ever become conscious again.

Initial one option only.

\_\_\_\_\_\_\_ **I would want** doctors to attempt treatments that sustain life. These include

CPR and xxx.

\_\_\_\_\_\_\_ **I would want** to extend my life with artificial feeding and

hydration. **I would not want** doctors to attempt other treatments to sustain

life.

\_\_\_\_\_\_\_ **I would not want** doctors to attempt treatments to sustain life. I **would not**

**want** artificial feeding and hydration.

\_\_\_\_\_\_\_ **I would want** my health care representative to decide for me after talking

with my health care provider.

|  |
| --- |
| You may use this space or attach pages to provide more about what kind of care you would want or not want. |

1. **Quality of life:**

A terminal condition or advanced illness may put severe limits on what a person can do and how they feel. Think about what is important in your life. What things would you still want to be able to do?

Check all that apply.

\_\_\_ Communicate with friends and family.

\_\_\_ Be free from long-term severe pain and suffering.

\_\_\_ Know who I am and who I am with.

\_\_\_ Live without being hooked up to machines.

\_\_\_ Participate in activities that have meaning to me.

\_\_\_ Other (please complete the space below).

|  |
| --- |
| You may use this space or attach pages to say more about what gives meaning to your life. |

1. Would you want your health care representative to take into account your **religious, faith or spiritual beliefs**? They can be rituals, sacraments, denying blood product transfusions and more.

|  |
| --- |
| You may use this space to share about your beliefs. |

**4. More Information**

Use this section if you want your health care representative and providers to have more information about you.

A.Below you can **share about your life, beliefs and values.** This could help your health care representative and providers make decisions about your health care.This might include family history, experiences with the health care, cultural background, career, social support system, and more.

|  |
| --- |
| You may use this space or attach pages to say more about what you want them to know. |

B**.** You may attach to this form **documents that you think would be helpful** to your health care representative and providers. What you attach will be part of your Advance Directive.

|  |
| --- |
| You may list documents you have attached here. |

**C. Inform others:**

You can allow your health care representative and providers to discuss your health status and care with the people you write in below. The people below are not allowed to make any decisions about your care.

Name Relationship Phone Email

\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **MY SIGNATURE**.

My signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **WITNESS**.

COMPLETE EITHER A OR B WHEN YOU SIGN.

1. NOTARY:

State of

County of

Signed or attested before me on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 2\_\_\_\_\_, by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public – State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

B. WITNESS DECLARATION:

The person completing this form is personally known to me or has provided proof of identity, has signed or

acknowledged the person’s signature on the document in my presence and appears to be not under duress

and to understand the purpose and effect of this form. In addition, I am not the person’s health care

representative or alternative health care representative, and I am not the person’s attending health care

provider.

Witness Name (print):

Signature: Date:

Witness Name (print):

Signature: Date:

1. **ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE.**

I accept this appointment and agree to serve as health care representative.

Health care representative:

Printed name:

Signature or other verification of acceptance:

Date:

First alternate health care representative:

Printed name:

Signature or other verification of acceptance:

Date:

Second alternate health care representative:

Printed name:

Signature or other verification of acceptance:

Date: