ADVANCE DIRECTIVE FOR HEALTH CARE (STATE OF OREGON)

The Advance Directive allows you to share how you would make decisions about your health care if you are not able to express them yourself. It is important that you discuss your Advance Directive and your wishes with your health care representative. This allows your health care representative to make decisions that are consistent with your wishes.

We recommend that you complete the entire Advance Directive. To appoint a health care representative, you must complete Sections 1, 2, 5, 6, and 7. In addition, 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: _____

2. 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: _____

3. INFORMATION FOR MY HEALTH CARE REPRESENTATIVE.

This section is the place for you to express your wishes, values and goals for care and to provide guidance for your health care representative and your health care providers. If you did not choose a health care provider or if they cannot be reached, you can direct your care with the choices you make below.

A. The three scenarios below will help you think about the kinds of life support decisions your health care representative may face. For each scenario, choose the one option that most closely fits your preference for extending your life.

1. Terminal Condition. If I have an illness that is incurable and irreversable and, that even with the administration of life-sustaining procedures, my physicians believe will result in my death within six months:

(Initial one option only)

_____I DO NOT WANT life sustaining procedures and do not want artificially administered

nutrition and hydration.

_____I DO NOT WANT life sustaining procedures, EXCEPT that I would want to extend my life with artificially administered nutrition and hydration.

_____I WANT life sustaining procedures.

_____I AM NOT SURE what I would want.

2. **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:

(Initial one option only)

_____I DO NOT WANT life sustaining procedures and do not want artificially administered nutrition and hydration.

_____I DO NOT WANT life sustaining procedures, EXCEPT that I would want to extend my life with artificially administered nutrition and hydration.

_____I WANT life sustaining procedures.

_____I AM NOT SURE what I would want.

3. **Permanently Unconscious.** If I am unconscious and it is very unlikely that I will ever become conscious again:

(Initial one option only)

_____I DO NOT WANT life sustaining procedures and do not want artificially administered nutrition and hydration.

_____I DO NOT WANT life sustaining procedures, EXCEPT that I would want to extend my life with artificially administered nutrition and hydration.

_____I WANT life sustaining procedures.

_____I AM NOT SURE what I would want.

If you wish, use this space or attach pages to provide additional information.

B. **Quality of life:** When I think about what will matter most to me at the end of my life, I want to be able to (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 are meaningful to me.
___Other (please complete space below).

If you wish, use this space or attach pages to provide additional information.

C. **Which religious, faith or spiritual community do you identify with, if any?**
_____

My health care representative should consider the following religious, faith and/or spiritual beliefs (e.g., rituals and sacraments, avoiding blood product transfusions, etc.):

If you wish, use this space or attach pages to provide additional information.

4. Additional Information

A. **I want my health care representative and providers to have this additional information about me.** Below you can share basic information about your lifetime experiences, beliefs and values that could help your health care representative and health care providers make decisions about your health care and where you prefer to receive care (information might include family history, experiences with the health care system, cultural background, deeply held beliefs, career, social support system, etc.):

If you wish, use this space or attach pages to provide additional information.

B**. You may attach documents or information to this form, including directives designed for unique circumstances that you think would be helpful to your health care representative and health care providers.**

I have attached the documents listed below. Please consider them part of my Advance Directive.

C. Consultation with others: I authorize my health care representative and providers to discuss my condition and care with the following people, understanding that they are not empowered to make any decisions regarding my care, unless I have appointed them as my health care representative(s). This is for the purpose of sharing personal health information and to comply with HIPAA.

Name Relationship Contact information (phone, email)

_____

_____

_____

5. MY SIGNATURE.

My signature: _____ DATE: _____

6. WITNESS.

COMPLETE EITHER A OR B WHEN YOU SIGN.

A. 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: _____

7. 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: _____