ADVANCE DIRECTIVE DECLARATION

I, Pat Whole Name (First Name First), being of sound mind, willfully and voluntarily make this declaration to be followed if I become incompetent. This declaration reflects my firm settled commitment to refuse life-sustaining treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw life-sustaining treatment that serves only to prolong the process of dying if I should be in terminal condition or in a state of permanent unconsciousness.

I direct that treatment be limited to measures to keep me comfortable and to relieve pain, including any pain that might occur by withholding or withdrawing life-sustaining treatment.

In addition, if I am in the condition described above, I feel especially strongly about the following forms of treatment:

I DO	I DO NOT	
☐	☐	want cardiac resuscitation.
☐	☐	want mechanical respiration.
☐	☐	want feeding tube.
☐	☐	want other artificial or invasive form of nutrition (food).
☐	☐	want other artificial or invasive form of hydration (water).
☐	☐	want blood or blood products.
☐	☐	want any form of surgery.
☐	☐	want any invasive diagnostic tests.
☐	☐	want kidney dialysis.
☐	☐	want antibiotics.
☐	☐	want other:

I realize that if I do not specifically indicate my preference regarding any of the forms of treatment listed above, I may receive that form of treatment.

Other Instructions:

I DO	I DO NOT	
☐	☐	want to donate my organs upon death.
☐	☐	want to designate a surrogate to make medical treatment decisions for me if I should be incompetent in a terminal condition or in a state of permanent unconsciousness. *Surrogate (name and address):* *Substitute Surrogate (name and address):*

I made this declaration on Wednesday April 9, 2014
Your Signature:
Address: Pat Address Line 1
Pat Address Line 2
Pat Address Line 3

The above named individual or a person on behalf of and at the direction of the individual knowingly and voluntarily signed this writing by signature or mark in my presence.

Witness's Signature:
Address:

Witness's Signature:

ADVANCE DIRECTIVES

Patient: Pat Whole Name (First Name First)
Date Given: 00/00/0000

DOB: Pat DOB
Staff initial:

Advanced Directives Initiated

☐ DNR	Date Initiated: 00/00/0000
☐ Living Will	Date Initiated: 00/00/0000
☐ Health Care Proxy	Date Initiated: 00/00/0000

Physician and/or provider
Signature:

Date: 00/00/0000

Review of this Form

Date	Review's Name/and Signature	Outcome of Review
00/00/0000		
00/00/0000		
00/00/0000		
00/00/0000		