

THE LIVING WILL OF _____

MY HEALTH CARE AGENT

If I am no longer able to make my own health care decisions, this form names the person I choose to make those choices for me. This person will be my Health Care Agent. This person will make health care choices if both these things happen:

1. My attending or treating doctor finds I am no longer able to make health care choices, AND
2. Another health care professional agrees that this is true.

THE PERSON I CHOOSE AS MY HEALTH CARE AGENT IS:

First Choice Name	Phone
Address	City, State & Zip

If this person is not able or willing to make these choices for me, OR is legally separated or divorced from me, OR this person has died, these people are my next choices:

Second Choice Name	Phone
Address	City, State, & Zip

Third Choice Name

Phone

Address

City, State & Zip

I understand that my Health Care Agent can make health care decisions for me. I want my agent to be able to do the following: (delete anything you do not want your agent to do, or add, etc.)

Make choices for me about my medical care or services, like tests, medicine or surgery. This care or service could be to find out what my health problem is, or how to treat it. It can also include care to keep me alive. If the care or treatment has already started, my Health Care Agent can keep it going or have it stopped.

Interpret any instructions I have given in this form or given in other discussions, according to my Health Care Agent's understanding of my wishes and values.

Arrange for admission to a hospital, hospice or nursing home for me. My Health Care Agent can hire any kind of health care worker I may need to help or take care of me. My Agent may also fire a health care worker if needed.

Make the decision to request, take away or not give medical treatments, including artificially-provided food and water, and any other treatments to keep me alive.

See and approve release of my medical records and personal files. If I need to sign my name to get any of these files, my Health Care Agent can sign for me.

Move me to another state to get the care I need or to carry out my wishes.

Authorize or refuse to authorize any medication or procedure.

Take any legal action needed to carry out my wishes.

Donate tissues as I request that are allowed by law.

Apply for Medicare, Medicaid or other programs or insurance benefits for me. My Health Care Agent can see my personal files, like bank records, to gather information to fill out these forms.

(List any additions below:)

THE KIND OF MEDICAL TREATMENT I WANT

I believe that I should be treated with dignity. When the time comes that I am very sick and I am not able to speak for myself, I want the following wishes and any other directions that I have given to my Health Care Agent, to be respected and followed:

I do not want to be in pain. I want my doctor to give me sufficient medication to relieve my pain, even if that means that I will be drowsy or sleep more than I would otherwise.

I do not want anything done or omitted by my doctors or nurses with the intention of taking my life.

I want to be offered food and fluids by mouth and kept clean and warm.

LIFE SUPPORT means any medical procedure, device or medication to keep me alive. Life-support treatment includes: medical devices put in me to help me to breathe; food and water supplied by medical device (tube feeding); cardiopulmonary resuscitation (CPR); major surgery; blood transfusions/ dialysis; antibiotics; and anything else meant to keep me alive.

The kind of medical treatment I desire or do not want is expressed below. I want my Health Care Agent, my family, my doctors and other health care providers, my friends and others to know these directions:

When Close To Death:

If my doctor and another health care professional both decide that I am likely to die within a short period of time, and life-support treatment would only delay the moment of my death, (Select one of the following or enter your own wishes):

I want life-supporting treatment.

I do not want life-support treatment. If it has been started, I want it stopped.

I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In a Coma and not expected to wake up or recover:

If my doctor and another health care professional both decide that I am in a coma from which I am not expected to wake-up or recover, and I have brain damage, and life-support treatment would only delay the moment of my death, (Select one of the following or enter your own wishes):

I want to have life-support treatment

I do not want life-support treatment. If it has been started, I want it stopped.

I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

Permanent and severe brain damage and not expected to recover:

If my doctor and another health care professional both decide that I have permanent and severe brain damage, (for example I can open my eyes but I cannot speak or understand, and I am not expected to get better, and I have brain damage, and life-support treatment would only delay the moment of my death, (Select one of the following or enter your own wishes):

I want to have life-support treatment

I do not want life-support treatment. If it has been started, I want it stopped.

I want to have life-support treatment if my doctor believes it could help. But I want my doctor to stop giving me life-support treatment if it is not helping my health condition or symptoms.

In another condition under which I do not wish to be kept alive:

If there is another condition under which you do not wish to have life-support treatment, identify or describe it here. For example, you might identify "end stage condition" which means that your health has gotten worse, you are not able to take care of yourself in any way mentally or physically. Life-support treatment will not help you recover. You might say:

I do not wish to have life-support treatment. In this condition I believe that the costs and burdens of life-support treatment are too much and not worth the benefits to me. Therefore in this condition, I do not want life-support treatment.

MY COMFORT

I believe that I should be treated with dignity near the end of my life. I understand that others may not be able to do these things or that they may not be required by law to do them.

I do not want to be in pain. I want my doctor to give me sufficient medication to relieve my pain, even if that means that I will be drowsy or sleep more than I would otherwise.

If I show signs of depression, nausea, shortness of breath, or hallucinations, I want my caregivers to do whatever they can to help me.

I wish to have a cool moist cloth placed on my head if I have a fever.

I want my lips and mouth kept moist to stop dryness.

I wish to have warm baths often. I wish to be kept fresh and clean at all times

I wish to be massaged with warm oils as often as I can be.

I wish to have my favorite music played if possible until my time of death.

I wish to have personal care like shaving, nail clipping, hair brushing and teeth brushing as long as they do not cause me pain or discomfort.

I wish to have readings I have selected read aloud when I am near death.

How I Wish To Be Treated

I wish to have people with me when possible. I wish to have someone with me when it seems that my death may come at any time.

I wish to have my hand held and to be talked to when possible, even if I do not seem to respond to the voice or touch of others.

I wish to have others at my side praying for me when possible.

I wish to be cared for with kindness and cheerfulness, not sadness.

I wish to have pictures of my loved ones in my room, near my bed.

If I am not able to control my bowel or bladder functions, I wish for my clothes and bed linens to be kept clean and for them to be changed as soon as possible

if they have been soiled.

I would like to die in my home, if possible.

What I Want My Loved Ones To Know

I wish my family and friends to know that I love them.

I ask my family members to make peace with each other before my death.

I ask my friends and family to remember what life was like before I became seriously ill.

I ask my family, friends and caregivers to respect my wishes, even if they do not agree with them.

After my death I would like my body to be (buried) (cremated), and my remains should be placed in the following location _____.

The following person knows my funeral wishes

_____.

If there is to be a memorial service for me, I wish it to include the following (list music, readings or any other specific requests that you may have).

Add any other specific wishes - (the donation of body parts, for example)

SIGNATURE

I _____, ask that my family, my doctors and other health care providers, my friends and all others, follow my wishes as communicated by my Health Care Agent or as is otherwise expressed in this form. This form becomes valid when I am unable to make decisions or speak for myself. If any part of this form cannot be legally followed, I ask that all other parts of this form be followed. I also revoke any health care advance directives I have made before.

Signature

Social Security Number

Address

Phone

Date

WITNESS STATEMENT

I, the witness, declare that the person who signed or acknowledged this form (hereafter "person") is personally known to me, that he/she signed or acknowledged this form in my presence, and that he/she appears to be of sound mind and under no duress, fraud or undue influence.

I also declare that I am over 18 years of age and am NOT:

The individual appointed as (agent/proxy/surrogate/patient advocate/ representative) by this document or his/her successor,

The person's health care provider including owner or operator of a health, long-term care, or other residential or community care facility serving the person,

An employee of the person's health care provider,

Financially responsible for the person's health care,

An employee of a life or health insurance provider for the person,

Related to the person by blood, marriage, or adoption, and,

To the best of my knowledge, a creditor of the person or entitled to any part of his/her estate under a will or codicil, by operation of law.

Signature of witness number one

Printed name of Witness

Address

Phone

Signature of witness number two

Printed name of witness

Address

Phone