

Patient's Advance Directive

To My Family, My Physician, My Clergyman, My Substitute Decision-Maker in the Durable Power of Attorney:

I, _____, being of sound mind, make this statement as an indication of my choice of medical care and as a directive to be followed if I become unable to participate in decisions regarding my health care. These instructions reflect my commitment to decline medical treatment under the circumstances indicated below.

I direct my attending physician to withhold or withdraw treatment that serves only to prolong the process of my dying if I should be in an incurable or irreversible physical condition with no reasonable expectation of recovery.

These instructions apply if I am (a) in a terminal condition; (b) permanently unconscious; (c) if I am conscious but have irreversible brain damage and will never regain the ability to make decisions and express my wishes.

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 treatment.

If I am in any one of the conditions described above, I have indicated my wishes in regard to the following forms of treatment:

(Please check your choices.)

- | | |
|------------------------|--|
| Cardiac Resuscitation | <input type="checkbox"/> I do want |
| | <input type="checkbox"/> I do not want |
| Mechanical Respiration | <input type="checkbox"/> I do want |
| | <input type="checkbox"/> I do not want |
| Feeding Tubes | <input type="checkbox"/> I do want |
| | <input type="checkbox"/> I do not want |
| Kidney Dialysis | <input type="checkbox"/> I do want |
| | <input type="checkbox"/> I do not want |
| Chemotherapy | <input type="checkbox"/> I do want |
| | <input type="checkbox"/> I do not want |
| Antibiotics | <input type="checkbox"/> I do want |
| | <input type="checkbox"/> I do not want |
| Intravenous Fluids | <input type="checkbox"/> I do want |
| | <input type="checkbox"/> I do not want |

(For additional instructions add sheet(s) as necessary.)

These directives express my right to refuse treatment and they are instructions to my substitute decision-maker as constituted in the Durable Power of Attorney instrument. I intend that my instructions be carried out unless I have rescinded them in a new written declaration or by a clear oral expression that I have changed my mind.

Signature _____ Date _____

Witness _____

My designated decision-maker is _____

whose address and current phone is _____

The standard operating procedures of most health care facilities assume that you would want life-sustaining procedures unless you indicate otherwise.