

ADVANCE DIRECTIVE

YOU DO NOT HAVE TO FILL OUT AND SIGN THIS FORM

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

This is an important legal document. It can control critical decisions about your health care. Before signing, consider these important facts:

Facts About Part B (Appointing a Health Care Representative)

You have the right to name a person to direct your health care when you cannot do so. This person is called your "health care representative." You can do this by using Part B of this form. Your representative must accept on Part E of this form.

You can write in this document any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

Facts About Part C (Giving Health Care Instructions)

You also have the right to give instructions for health care providers to follow if you become unable to direct your care. You can do this by using Part C of this form.

Facts About Completing This Form

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this advance directive, it will not expire. If you have set an expiration date, and you become unable to direct your health care before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation.

Despite this document, you have the right to decide your own health care as long as you are able to do so.

If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes or add words that better express your wishes. Witnesses must sign PART D.

Print your NAME, BIRTHDATE AND ADDRESS here:

(Name)

(Birthdate)

(Address)

Unless revoked or suspended, this advance directive will continue for:

INITIAL ONE:

_____ My entire life

_____ Other period (___ Years)

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint _____ as my health care representative. My representative's address is _____ and telephone number is _____ .

I appoint _____ as my alternate health care representative. My alternate's address is _____ and telephone number is _____ .

I authorize my representative (or alternate) to direct my health care when I can't do so.

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator or employee of your health care facility, unless that person is related to you by blood, marriage or adoption or that person was appointed before your admission into the health care facility.

1. Limits.

Special Conditions or Instructions: _____

INITIAL IF THIS APPLIES:

_____ I have executed a Health Care Instruction or Directive to Physicians. My representative is to honor it.

2. Life Support.

"Life support" refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

INITIAL IF THIS APPLIES:

_____ My representative MAY decide about life support for me. (If you don't initial this space, then your representative MAY NOT decide about life support.)

3. Tube Feeding.

One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

INITIAL IF THIS APPLIES:

_____ My representative MAY decide about tube feeding for me. (If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

(Signature of person making appointment)

(Date)

PART C: HEALTH CARE INSTRUCTIONS

NOTE: In filling out these instructions, keep the following in mind:

- * The term "as my physician recommends" means that you want your physician to try life support if your physician believes it could be helpful and then discontinue it if it is not helping your health condition or symptoms.
- * "Life support" and "tube feeding" are defined in Part B above.
- * If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.
- * You will get care for your comfort and cleanliness, no matter what choices you make.
- * You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

1. Close to Death. If I am close to death and life support would only postpone the moment of my death:

A. INITIAL ONE:

- I want to receive tube feeding.
- I want tube feeding only as my physician recommends.
- I DO NOT WANT tube feeding.

B. INITIAL ONE:

- I want any other life support that may apply.
- I want life support only as my physician recommends.
- I want NO life support.

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

A. INITIAL ONE:

- I want to receive tube feeding.
- I want tube feeding only as my physician recommends.
- I DO NOT WANT tube feeding.

B. INITIAL ONE:

- I want any other life support that may apply.
- I want life support only as my physician recommends.
- I want NO life support.

3. 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:

A. INITIAL ONE:

- I want to receive tube feeding.
- I want tube feeding only as my physician recommends.
- I DO NOT WANT tube feeding.

B. INITIAL ONE:

- I want any other life support that may apply.
- I want life support only as my physician recommends.
- I want NO life support.

4. Extraordinary Suffering. If life support would not help my medical condition and would make me suffer permanent and severe pain:

A. INITIAL ONE:

- I want to receive tube feeding.
- I want tube feeding only as my physician recommends.
- I DO NOT WANT tube feeding.

B. INITIAL ONE:

- I want any other life support that may apply.
- I want life support only as my physician recommends.
- I want NO life support.

5. General Instruction.

INITIAL IF THIS APPLIES:

I do not want my life to be prolonged by life support. I also do not want tube feeding as life support. I want my doctors to allow me to die naturally if my doctor

and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

6. Additional Conditions or Instructions. (Insert description of what you want done.)

7. Other Documents. A "health care power of attorney" is any document you may have signed to appoint a representative to make health care decisions for you.

INITIAL ONE:

_____ I have previously signed a health care power of attorney. I want it to remain in effect unless I appointed a health care representative after signing the health care power of attorney.

_____ I have a health care power of attorney, and I REVOKE IT.

_____ I DO NOT have a health care power of attorney.

SIGN HERE TO GIVE INSTRUCTIONS

(Signature)

(Date)

PART D: DECLARATION OF WITNESSES

We declare that the person signing this advance directive:

- (a) Is personally known to us or has provided proof of identity;
- (b) Signed or acknowledged that person's signature on this advance directive in our presence;
- (c) Appears to be of sound mind and not under duress, fraud or undue influence;
- (d) Has not appointed either of us as health care representative or alternative representative; and
- (e) Is not a patient for whom either of us is attending physician.

Witnessed By:

(Signature of Witness/Date)

(Printed Name of Witness)

(Signature of Witness/Date)

(Printed Name of Witness)

NOTE: One witness must not be a relative (by blood, marriage or adoption) of the person signing this advance directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate or be employed at a health care facility where the person is a patient or resident.

PART E: ACCEPTANCE BY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest. I understand that this document allows me to decide about that person's health care only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider if known to me.

(Signature of Health Care Representative)

(Signature of Alternate Health Care Representative)

(Printed Name)

(Printed Name)

YOUR RIGHT TO MAKE HEALTH CARE DECISIONS IN OREGON

DO I HAVE TO ACCEPT ALL MEDICAL TREATMENT THAT IS AVAILABLE? No. You have a right to accept or refuse any proposed medical tests or treatment.

HOW WILL I KNOW HOW TO DECIDE? Your doctor will tell you what treatment or testing he or she recommends. Your doctor will also tell you that there may be alternatives and risks. If you want to know more, your doctor will tell you about the treatment or test, the available alternatives and the material risks. When you have enough information, you decide whether to have the test or treatment.

HOW CAN I PLAN AHEAD FOR A TIME WHEN I MAY BE UNABLE TO MAKE DECISIONS? Oregon has an official form you can sign to cover future situations where you are unable to decide. The form is called an Advance Directive. It has two main parts, one called "Health Care Instructions" and the other called "Appointment of Health Care Representative."

HOW CAN I CONTROL WHAT HEALTH CARE I GET IF I BECOME UNABLE TO MAKE HEALTH CARE DECISIONS? By completing the "Health Care Instructions" on the Advance Directive form. This lets you control the medical treatment you get, and under what circumstances you will get it.

HOW DO I APPOINT SOMEONE ELSE TO ACT FOR ME? By making the "Appointment of Health Care Representative" on the Advance Directive form. This lets you select another adult as your representative. That person should be someone you trust to decide about your health care when you cannot do so yourself. Your representative cannot act for you unless you become unable to make your own decisions. You may also appoint an alternate representative. The representative and any alternate must sign the form agreeing to serve. The Advance Directive form lets you say what decisions those persons may make for you. It is a good idea to discuss your wishes with the person(s) you appoint.

HOW DOES AN ADVANCE DIRECTIVE TAKE EFFECT? If you are an adult able to make your own decisions, you can sign an Advance Directive at any time. You do not have to fill out and sign the form if you don't want to. But if you do, your doctor must follow it or allow you to be transferred to a doctor who will. Signing the form will not affect your insurance.

HOW DO I OBTAIN AND SIGN MY ADVANCE DIRECTIVE? Health care facilities and some stationery stores have the official form. Lawyers and doctors may have one or help you obtain one. In Oregon, the only reliable way to be sure your wishes are followed is to use the official form. Read and follow the "Important Information" at the beginning of the form. If the printed form does not express your wishes, you may cross words out or write your own words in. Do not add anything about money or property. The form must be signed by you and two witnesses who must satisfy special requirements. Send a copy to your doctor and to the person you choose as a representative. Keep the original where it can be easily found.

HOW LONG DOES AN ADVANCE DIRECTIVE REMAIN IN EFFECT? You may write in an expiration date. If you do not, the form will be good until you revoke it. You may revoke it at any time and in any manner, but the best way is by notifying those who have your form. Unless you say otherwise on the form, a new Advance Directive takes priority over an older one. Your representative can withdraw at any time by notifying you or your doctor. Divorce revokes appointment of a spouse, but you can reaffirm appointment by signing a new directive.

ARE THERE HEALTH CARE DECISIONS MY REPRESENTATIVE CANNOT MAKE?

Yes. Your representative may not decide about mental health treatment, sterilization, abortion, psychosurgery, shock treatment, or mercy killing. You can make advance decisions about mental health treatment using an official form called a "Declaration for Mental Health Treatment," available from some stationery stores or your local mental health agency.

HOW WILL MY REPRESENTATIVE MAKE DECISIONS FOR ME? Your representative must act in the way you specify on an Advance Directive form. He or she must also follow your known wishes. If your representative does not know what you want, he or she must act in your best interest. Your representative does not have to pay your medical bills.

CAN MY REPRESENTATIVE PREVENT OR STOP LIFE SUPPORT? Yes, if your Advance Directive form says so. If you have not given specific instructions, the law specifies four critical medical conditions in which your representative may decide about life support for you:

- * Life support would not benefit you and would cause you permanent and severe pain;
- * You are close to death and life support would only postpone the moment of your death;
- * You are permanently unconscious; or
- * You are in an advanced stage of a progressive, fatal illness.

The law also allows your representative to decide about life support in other circumstances you designate on the form. But you must get routine care for your cleanliness and comfort. Life support will not be prevented or stopped if your form says you would want it continued.

CAN MY REPRESENTATIVE PREVENT OR STOP FOOD AND WATER BY TUBE?

Yes, if your Advance Directive form says so. In addition, your representative may prevent or stop tube feeding if you have clearly said that you would refuse it. Otherwise, you must get tube feeding that would prolong your life, unless you have one

of the four critical medical conditions that the law specifies. Your representative cannot refuse food or water you can take in a normal way.

HOW ARE DECISIONS MADE FOR ME IF I DO NOT HAVE AN OFFICIAL FORM? If you have one of the four critical medical conditions that the law specifies, an Oregon statute allows close relatives and friends to decide about life support for you. Otherwise, the law does not clearly identify the decisions that relatives or friends may make for you. Relatives, friends or others may seek clear authority from a court by being appointed your guardian.

IS AN ADVANCE DIRECTIVE I SIGNED UNDER ANOTHER STATE'S LAW GOOD IN OREGON? Yes, if you did not live in Oregon when you signed it. Oregon residents may only use an Oregon form.

ARE OREGON'S EARLIER OFFICIAL FORMS STILL GOOD? Yes, if you signed a Power of Attorney for Health Care or a Directive to Physicians before November 4, 1993, you can still use it. Even though the old forms are similar to the Advance Directive, there are some big differences:

- * A Directive to Physicians is a legal statement that you do NOT want artificial life support which would only postpone your death when you are terminally ill.

- * A Power of Attorney for Health Care allows your representative to stop life support if you checked the line on the form referring to "life-sustaining procedures". It allows your representative to prevent or stop food and water by tube if you checked the line on the form referring to "artificially administered nutrition and hydration". Otherwise, the form allows your representative to forego tube feeding for you only if you have one of the four critical medical conditions that the law specifies.

- * Unless you sign an Advance Directive, the Directive to Physicians remains in effect unless or until you revoke it. The Power of Attorney for Health Care expires after seven years unless you are already incapable when it expires.

HOW CAN I FIND OUT MORE? By calling Oregon Health Decisions, a private nonprofit corporation (503) 241-0744 or toll free 1-800-422-4805), or by consulting an attorney.

NOTE: This statement reflects Oregon law effective November 4, 1993. It is a general summary of the rights of competent adults in Oregon. It does not contain all the technical details of the law. Also, it does not deal with decisions for minors, for those who are now mentally incapable, or about treatment outside Oregon.

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