



ADVANCE DIRECTIVE FORM

Part One: Designation of Health Care Surrogate

Name: _____
(Last) (First) (Middle Initial)

In the event that I have been determined to be incapacitated to provide informed consent for medical treatment and surgical and diagnostic procedures, I wish to designate as my surrogate for health care decisions:

Name: _____

Address: _____ Zip Code: _____

Phone: () _____

If my surrogate is unwilling or unable to perform his or her duties, I wish to designate as my alternate surrogate:

Name: _____

Address: _____ Zip Code: _____

Phone: () _____

I fully understand that this designation will permit my designee to make health care decisions and to provide, withhold, or withdraw consent on my behalf; to apply for public benefits to defray the cost of health care; and to authorize my admission to or transfer from a health care facility.

When making health care decisions for me, my health care surrogate should think about what action would be consistent with past conversations we have had, my treatment preferences as expressed in Part Two (if I have filled out Part Two), my religious and other beliefs and values, and how I have handled medical and other important issues in the past. If what I would decide is still unclear, then my health care surrogate should make decisions for me that my health care surrogate believes are in my best interest, considering the benefits, burdens, and risks of my current circumstances and treatment options.



Part two: declaration

Declaration made this _____ day of _____, _____
(month) (day) (year)

I, _____
willfully and voluntarily make known my desire that my dying not be artificially prolonged under the circumstances set forth below, and I do hereby declare that:

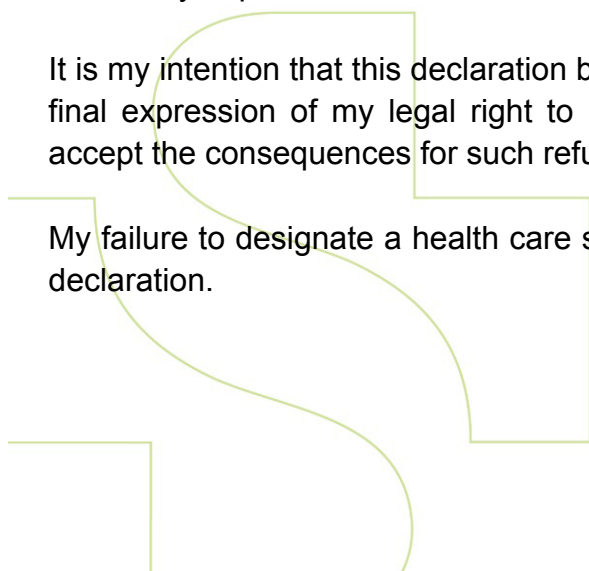
If at any time I am incapacitated and (initial all that apply):

- I have a terminal condition, or
- I have an end-stage condition, or
- I am in a persistent vegetative state

and if my attending or treating physician and another consulting physician have determined that there is no reasonable medical probability of my recovery from such condition, I direct that life-prolonging procedures be withheld or withdrawn when the application of such procedures would serve only to prolong artificially the process of dying, and that I be permitted to die naturally with only the administration of medication or the performance of any medical procedure deemed necessary to provide me with comfort care or to alleviate pain.

It is my intention that this declaration be honored by my family and physician as the final expression of my legal right to refuse medical or surgical treatment and to accept the consequences for such refusal.

My failure to designate a health care surrogate in Part One shall not invalidate this declaration.





Part two: organ donation (optional)

I hereby make this anatomical gift, if medically acceptable, to take effect on death.
The words and marks below indicate my desires:

I give (initial one choice below):

Any needed organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education

Only the following organs, tissues, or eyes for the purpose of transplantation, therapy, medical research, or education:

My body for anatomical study if needed. Limitations or special wishes, if any:

I have already arranged to donate

Any needed organs, tissues, or eyes,

The following organs, tissues, or eyes:

To the following donee:

Name:

Address:

 Zip Code:

Phone: ()
