Oregon Advance Directive for Health Care

This **Advance Directive form** allows you to:

- Share your goals and wishes for health care if you were not able to express them yourself.
- Name a person to make your health care decisions if you could not make them for yourself. This person is called your health care representative.

Be sure to discuss your Advance Directive and your wishes with your health care representative. This will allow them to make decisions that reflect your wishes.

It is best to complete this entire form.

- In Sections 1, 2, 5, 6, and 7 you appoint a health care representative.
- In Sections 3 and 4 you provide instructions about your care.

This form may be used in Oregon to choose a person to make health care decisions for you if you become too sick to speak for yourself. The person is called a health care representative. If you do not have an effective health care representative appointment and become too sick to speak for yourself, a health care representative will be appointed for you in the order of priority set forth in ORS 127.635(2).

This form also allows you to express your values and beliefs with respect to health care decisions and your preferences for health care.

- If you have completed an advance directive in the past, this new advance directive will replace any older directive.

- You must sign this form for it to be effective. You must also have it witnessed by two witnesses or a notary. Your appointment of a health care representative is not effective until the health care representative accepts the appointment.

- If your advance directive includes directions regarding the withdrawal of life support or tube feeding, you may revoke your advance directive at any time and in any manner that expresses your desire to revoke it.

- In all other cases, you may revoke your advance directive at any time and in any manner as long as you are capable of making medical decisions.

1. ABOUT ME

Name: _____ Date of Birth: _____

Telephone Numbers: (Home) _____ (Work) _____ (Cell) _____

Address: _____

Email: _____

2. MY HEALTH CARE REPRESENTATIVE.

I choose the following person as my health care representative to make health care decisions for me if I can't speak for myself.

Name: _____ Relationship: _____

Telephone Numbers: (Home) _____ (Work) _____ (Cell) _____

Address: _____

Email: _____

I choose the following people to be my alternate health care representatives if my first choice is not available to make health care decisions for me or if I cancel the first health care representative's appointment.

First alternate health care representative:

Name: _____ Relationship: _____

Telephone Numbers: (Home) _____ (Work) _____ (Cell) _____

Address: _____

Email: _____

Second alternate health care representative:

Name: _____ Relationship: _____

Telephone Numbers: (Home) _____ (Work) _____ (Cell) _____

Address: _____

Email: _____

3. My Health Care Instructions

This section is the place for you to express your wishes, values and goals for care. These provide guidance for your health care representative and health care providers.

You can direct your care with the choices you make below. This is the case even if you do not choose a health care representative or if they cannot be reached.

A. There are three cases below for you to **express your wishes**. They will help you think about the kinds of life support decisions your health care representative could face. For each case, choose the one option that most closely fits your wishes.

- **Terminal Condition**

  This is what I would want if…
  - I had an illness that could not be cured or reversed.
  - And my health care providers believed it would result in my death within six months, regardless of any treatments.

  Initial one option only**.**

  _____ **I would want** to try treatments to sustain my life. This includes using feeding tubes, IV fluids and breathing machines.

  _____ **I would want** to sustain my life with artificial feeding and hydration such as feeding tubes and IV fluids. **I would not want** other treatments to sustain my life, such as breathing machines.

  _____ **I would not want** treatments to sustain my life including using feeding tubes, IV fluids or breathing machines. **I would want** to be kept comfortable and be allowed to die naturally.

  _____ **I would want** my health care representative to decide for me. This would be after they talk with my health care providers and take into account the things that matter to me. I have expressed what matters to me in Section B below.

- **Advanced Illness**

  This is what I would want if…
  - I had an illness that were in an advanced stage.
  - It would not be likely that my condition would improve.
  - And I would never be able to:
    - Communicate by any means
    - Swallow food and water safely
    - Care for myself
    - Recognize my family and other people

  Initial one option only.

_____ **I would want** to try treatments to sustain my life. This includes using feeding tubes, IV fluids, and breathing machines.

_____ **I would want** to sustain my life with artificial feeding and hydration such as feeding tubes and IV fluids. **I would not want** other treatments to sustain my life, such as breathing machines.

_____ **I would not want** treatments to sustain my life including using feeding tubes, IV fluids or breathing machines. **I would want** to be kept comfortable and be allowed to die naturally.

_____ **I would want** my health care representative to decide for me. This would be after they talk with my health care providers and take into account the things that matter to me. I have expressed what matters to me in Section B below.

- **Permanently Unconscious**

  This is what I would want if…
  - I were not conscious.
  - And it would be very unlikely that I would ever become conscious again.

  Initial one option only.

_____ **I would want** to try treatments to sustain my life. This includes using feeding tubes, IV fluids, and breathing machines.

_____ **I would want** to sustain my life with artificial feeding and hydration such as feeding tubes and IV fluids. **I would not want** other treatments to sustain my life, such as breathing machines.

_____ **I would not want** treatments to sustain my life including using feeding tubes, IV fluids or breathing machines. **I would want** to be kept comfortable and be allowed to die naturally.

_____ **I would want** my health care representative to decide for me. This would be after they talk with my health care providers and take into account the things that matter to me. I have expressed what matters to me in Section B below.

You may write in this box or attach pages to say more about what kind of care you would want or not want.

B. **Quality of life:**

A terminal condition or advanced illness may put severe limits on what a person can do and how they feel. Think about what gives meaning to your life. What things would you still want to be able to do?

Check all that apply.

___ Communicate with family and friends.

___ Be free from long-term severe pain and suffering.

___ Know who I am and who I am with.

___ Live without being hooked up to machines.

___ Participate in activities that have meaning to me.

___ Other (Please complete the space below.)

You may write in this box or attach pages to say more about what matters to you.

C. Would you want your health care representative to take into account your **religious, faith or spiritual beliefs**? They can be rituals, sacraments, denying blood product transfusions and more.

You may write in this box or attach pages to say more about your religious, faith or spiritual beliefs.

4. More Information

Use this section if you want your health care representative and health care providers to have more information about you.

A. Below you can **share about your life, beliefs and values.** This could help your health care representative and health care providers make decisions about your health care. This might include family history, experiences with health care, cultural background, career, social support system, and more.

You may write in this box or attach pages to say more about your life, beliefs and values.

B. If there is a choice about where you receive care, what would you prefer? Are there places you would want or not want to receive care? (For example, a hospital, a care home, a mental health facility, your home.)

You may write in this box or attach pages to say more about where you would prefer to receive care on not receive care.

C. You may attach to this form **other documents you think would be helpful** to your health care representative and health care providers. What you attach will be part of your Advance Directive.

You may list documents you have attached in this box.

D. **Inform others:**

You can allow your health care representative and health care providers to discuss your health status and care with the people you write in below. The people below are not allowed to make any decisions about your care.

Name Relationship Phone Email

_____

_____

_____

5. MY SIGNATURE.

My signature: _____ DATE: _____

6. WITNESS.

COMPLETE EITHER A OR B WHEN YOU SIGN.

A. NOTARY:

State of _____

County of _____

Signed or attested before me on _____, 20____, by _____.

_____

Notary Public – State of _____

B. WITNESS DECLARATION:

The person completing this form is personally known to me or has provided proof of identity, has signed or
acknowledged the person's signature on the document in my presence and appears to be not under duress
and to understand the purpose and effect of this form. In addition, I am not the person's health care representative or alternative health care representative, and I am not the person's attending health care provider.

Witness Name (print): _____

Signature: _____ Date: _____

Witness Name (print): _____

Signature: _____ Date: _____

7. ACCEPTANCE BY MY HEALTH CARE REPRESENTATIVE.

I accept this appointment and agree to serve as health care representative.

Health care representative:

Printed name: _____

Signature or other verification of acceptance: _____

Date: _____

First alternate health care representative:

Printed name: _____

Signature or other verification of acceptance: _____

Date: _____

Second alternate health care representative:

Printed name: _____

Signature or other verification of acceptance: _____

Date: _____