PREPARING A PRO-LIFE ADVANCE DIRECTIVE

YOU ARE NOT REQUIRED TO FILL OUT ANY PART OF THIS ADVANCE DIRECTIVE OR ANY OTHER DOCUMENT SUCH AS A POLST. NO ONE MAY FORCE YOU TO SIGN THIS DOCUMENT OR ANY OTHER OF ITS KIND.

1. Initial the 3rd option entitled "Other instructions:" in Section 3 of this advance directive.

2. It is strongly recommended that you **DO NOT** complete Section 4 of this Advance Directive entitled "DIRECTIONS REGARDING MY END OF LIFE CARE." Oregon law requires Section 4 to be included in this document but you do not have to fill it out. If you initial the wrong choice in Section 4 it will conflict with the pro-life language in Section 3.

   Some people may wish to continue certain types of medical treatment when they are terminally ill and in the final stages of life. Others may not.

3. If you wish to refuse some specific medical treatment, this document provides space to do so. You may make special conditions for your treatment when your **death is imminent**, meaning you will live no more than a week even if given all available medical treatment; or when you are incurably **terminally ill**, meaning you will live no more than three months even if given all available medical treatment.

4. It is VERY important that if you choose to identify treatments that you wish to refuse at the end of your life that you are very specific in listing what treatments you do not want. Do not simply say you don't want "extraordinary treatment" or that you don't want a treatment that is an "excessive burden." there is a danger that a vague description of what you do not want will be misunderstood or distorted so as to deny you treatment that you do want.

   Here are some examples of treatments you might—or might not—want to refuse at the end of your life: (see pg. 2 for other scenarios)
   - Cardiopulmonary resuscitation (CPR) if the cardiopulmonary arrest has been caused by my terminal illness or a complication of it.
   - - Surgery that would not cure me, would not improve either my mental or my physical condition, would not make me more comfortable, and would not help me to have less pain.
   - A treatment that will itself cause me severe, intractable, and long-lasting pain but will not cure me.

5. You do not have to refuse any treatments if you do not wish to. If you leave these sections blank, this pro-life advance directive will still be valid.

Finally, remember this is a legal document. If you have any questions or need further legal advice we would be happy to refer you to a pro-life attorney.

PRO-LIFE ADVANCE DIRECTIVE

Remember this is a legal document. Please read through all the packet information before filling out your advance directive. If you have any questions or need further legal advice we can refer you to a pro-life attorney.

Your pro-life advance directive is on the next page.

ADVANCE DIRECTIVE
(STATE OF OREGON)

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. INSTRUCTIONS TO MY HEALTH CARE REPRESENTATIVE.

If you wish to give instructions to your health care representative about your health care decisions, initial one of the following three statements:

___ To the extent appropriate, my health care representative must follow my instructions.

___ My instructions are guidelines for my health care representative to consider when making decisions about my care

___ Other instructions:

GENERAL PRESUMPTION FOR LIFE

In exercising the power to make health care decisions on my behalf, my health care representative must follow my instructions.

I direct my health care representative to make health care decisions consistent with my general desire for the use of medical treatment that would preserve my life, as well as for the use of medical treatment that can cure, improve, reduce or prevent deterioration in, any physical or mental condition.

I consider food (nutrition) and water (hydration), even when provided by artificial means, always to be ordinary means of preserving life, not medical treatment. I direct my health care representative to provide me with food and fluids, orally, intravenously, by tube, or by other means, including without limitation artificially administered nutrition and hydration as that term is defined in ORS 127.505, to the full extent necessary both to preserve my life and to assure me the optimal health possible.

I direct that medication to alleviate my pain be provided as long as the medication is not used in order to cause my death.

I direct that I be provided basic nursing care and procedures to provide comfort care.

I reject in any situation any treatment that directly uses an unborn or newborn child, or any tissue or organ of an unborn or newborn child who has been subject to an induced abortion.

I reject any treatments that use an organ or tissue of another person obtained in a manner that directly causes, contributes to, or hastens that person's death.

The instructions in this document are intended to be followed even if it is alleged that I have attempted suicide at some point after it is signed.

I request and direct that medical treatment and care be provided to me to preserve my life without discrimination based on my age, physical or mental disability, or the actual or anticipated "quality" of my life.

I direct that my life not be ended by assisted suicide or euthanasia, the latter meaning an action or omission that would directly and intentionally cause my death.

I direct that the following be provided:

- The administration of medication;
- Cardiopulmonary resuscitation (CPR); and
- The performance of all other medical procedures, techniques, and technologies, including surgery,

-all to the full extent necessary to correct, reverse, or alleviate life threatening or health impairing conditions or complications arising from those conditions.

WHEN MY DEATH IS IMMINENT

If I have an incurable terminal illness or injury, and I will die imminently – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only a week or less even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:

_____
_____
_____

WHEN I AM TERMINALLY ILL

If I have an incurable terminal illness or injury and even though death is not imminent I am in the final stage of that terminal condition – meaning that a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved, would judge that I will live only three months or less, even if lifesaving treatment or care is provided to me – the following may be withheld or withdrawn:

_____
_____
_____

IF I AM PREGNANT

If I am pregnant, I direct my health care provider(s) and health care representative to use all lifesaving procedures for myself with none of the above special conditions applying if there is a chance that prolonging my life might allow my child to be born alive. I also direct that lifesaving procedures be used even if I am legally determined to be brain dead if there is a chance that doing so might allow my child to be born alive. Except as I specify by writing my signature in the box below, no one is authorized to consent to any procedure for me that would result in the death of my unborn child.

If I am pregnant, and I am not in the final stage of a terminal condition as defined above, medical procedures required to prevent my death are authorized even if they may result in the death of my unborn child provided every possible effort is made to preserve both my life and the life of my unborn child.

_____
Signature of Principal

4. DIRECTIONS REGARDING MY END OF LIFE CARE.

In filling out these directions, keep the following in mind:

- The term "as my health care provider recommends" means that you want your health care provider to use life support if your health care provider believes it could be helpful, and that you want your health care provider to discontinue life support if your health care provider believes it is not helping your health condition or symptoms.
- The term "life support" means any medical treatment that maintains life by sustaining, restoring or replacing a vital function.
- The term "tube feeding" means artificially administered food and water.
- If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.
- You will receive care for your comfort and cleanliness no matter what choices you make.

A. Statement Regarding End of Life Care. You may initial the statement below if you agree with it. If you initial the statement, you may, but you do not have to, list one or more conditions for which you do not want to receive life support.

__ 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 health care provider to allow me to die naturally if my health care provider and another knowledgeable health care provider confirm that I am in any of the medical conditions listed below.

B. Additional Directions Regarding End of Life Care. Here are my desires about my health care if my health care provider and another knowledgeable health care provider confirm that I am in a medical condition described below:

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

INITIAL ONE:
__ I want to receive tube feeding.
__ I want tube feeding only as my health care provider recommends.
__ I DO NOT WANT tube feeding.

INITIAL ONE:
__ I want any other life support that may apply.
__ I want life support only as my health care provider recommends.
__ I DO NOT WANT life support.

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

INITIAL ONE:
__ I want to receive tube feeding.
__ I want tube feeding only as my health care provider recommends.
__ I DO NOT WANT tube feeding.

INITIAL ONE:
__ I want any other life support that may apply.
__ I want life support only as my health care provider recommends.
__ I DO NOT WANT life support.

c. 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:

INITIAL ONE:
__ I want to receive tube feeding.
__ I want tube feeding only as my health care provider recommends.
__ I DO NOT WANT tube feeding.

INITIAL ONE:
__ I want any other life support that may apply.
__ I want life support only as my health care provider recommends.
__ I DO NOT WANT life support.

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

INITIAL ONE:
__ I want to receive tube feeding.
__ I want tube feeding only as my health care provider recommends.
__ I DO NOT WANT tube feeding.

INITIAL ONE:
__ I want any other life support that may apply.
__ I want life support only as my health care provider recommends.
__ I DO NOT WANT life support.

C. Additional Instruction. You may attach to this document any writing or recording of your values and beliefs related to health care decisions. These attachments will serve as guidelines for health care providers. Attachments may include a description of what you would like to happen if you are close to death, if you are permanently unconscious, if you have an advanced progressive illness or if you are suffering permanent and severe pain.

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 _____, 2_____, by _____.
_____
Notary Public – State of Oregon

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 alternate 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: _____