



CONCLUSIONS
OREGON
Prepare & Protect

Pro-Life

ADVANCE DIRECTIVE

CONCLUSIONSOREGON.ORG

Table of Contents

PREPARING YOUR PRO-LIFE ADVANCE DIRECTIVE.....	1
--	---

BASIC DEFINITIONS TO KNOW.....	1
--------------------------------	---

Advance Directive.....	1
------------------------	---

Health Care Representative.....	1
---------------------------------	---

WHY FILL OUT A PRO-LIFE ADVANCE DIRECTIVE?.....	1
---	---

STEPS TO TAKE.....	2
--------------------	---

MEDICAL SCENARIOS.....	3
------------------------	---

LET'S SIT DOWN AND TALK.....	3
------------------------------	---

End of Life Care.....	3
-----------------------	---

Cardiopulmonary Resuscitation (CPR).....	3
--	---

Nutrition Through a Tube.....	4
-------------------------------	---

Alzheimer's or Dementia.....	4
------------------------------	---

Breathing With a Machine.....	5
-------------------------------	---

Managing Pain.....	5
--------------------	---

COMPLETING YOUR PRO-LIFE ADVANCE DIRECTIVE.....	6
---	---

Preparing Your Pro-life ADVANCE DIRECTIVE

Basic Definitions to Know

Advance Directive

By filling out your advance directive, you will create a legally operative document that preserves your end of life decisions. You will also appoint your health care representative, a person who will make decisions for you if you cannot make them for yourself. This person must agree to act in this role. Your advance directive will be followed if you should no longer be able to speak for yourself. The advance directive presented in this document is in the form required by ORS 127.529.

An advance directive is not the same as Portable Orders for Life Sustaining Treatment (POLST) as defined in ORS 127.663. You never have to sign a POLST.

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.

Health Care Representative

The person you appoint as your health care representative should understand your philosophy of life. They should also be someone you trust to advocate for your medical decisions in your advance directive. Your health care representative, armed with your advance directive, will have the legal power to make health care decisions for you should you no longer be able to communicate. It is also important that you appoint an alternative health care representative in case your primary representative is not available.

Why Fill Out a Pro-Life Advance Directive?

Enough legal protections have been removed from Oregon law to cause great concern that Oregonians' health care decisions and end-of-life wishes will not be fully protected.

This pro-life advance directive starts from the principle that the presumption should be for life. If you follow these instructions, you are giving directions to your health care representative to do his or her best to preserve your life until natural death.

It is important that you read through all the pages in this packet before you begin to fill out your pro-life advance directive. Even if you already have an advance directive, it is wise to fill out this advance directive as it will replace your old one.

Steps to Take

STEP ONE

Put your name on the front of the folder.

STEP TWO

Read through the scenarios as they are designed to help you think about the kind of care you want in potential medical situations.

STEP THREE

Read the suggestions for filling out an advance directive.

STEP FOUR

Fill out your advance directive and have it witnessed by two individuals (or by a notary).

STEP FIVE

Destroy any and all copies of previous advance directives.

STEP SIX

Provide a copy to your doctor(s) and other medical professionals.

STEP SEVEN

Put your original copy in a location where you or your health care representative can easily access it should this become necessary.

Conclusions Oregon cannot provide you with legal advice. If you have questions when filling out an advance directive, please contact your attorney. If you need a pro-life attorney, please email us at help@conclusionsoregon.org and we can refer you.

Medical Scenarios

Let's Sit Down and Talk

The purpose of this section is to assist you in exploring difficult situations with your loved ones. As you go through the following fictional scenarios, think about and discuss what you would want in each situation.

End of Life Care

Harry and Sally are in their early sixties and have been married for 44 years. They want to fill out an advance directive to preserve their medical decisions for the future. Both believe medical intervention and treatment is necessary if they were to need it. However, they are okay with only receiving comfort care should they be in their last few days of life and medical intervention would not prolong their lives or could accelerate death.

Comfort care focuses on relieving symptoms, not treatment, and can include the use of pain medication, oxygen, or food and water by mouth.

Cardiopulmonary Resuscitation (CPR)

Harry's family has a history of heart disease. This has caused some of his family members to have heart attacks in their late seventies. Harry wants emergency services to respond to a health crisis by giving him CPR and taking him to the nearest hospital so he can receive the necessary treatments. Sally agrees that she wants CPR in the same situation.

Sally works in a nursing home and knows that every patient will be given CPR unless they have a POLST that says otherwise. Sally and Harry have talked with their kids who know that when the time comes both Harry and Sally will move into a nursing home. Neither of them will fill out a POLST as they want CPR and to be taken to a hospital to be treated.

CPR is used to restart the heart when a person no longer has a heartbeat.

Nutrition Through a Tube

Years ago, Sally and Harry's granddaughter was in a severe car accident. She was in ICU for several weeks because she suffered brain damage. At first, she was in a coma on life support. She received water and other fluids (artificial hydration) through an IV. She also received artificial nutrition through a tube in her stomach. The doctors said she might stay in a coma for a while. They recommended the family consider terminating life support if there was no brain activity within the next few days. Thankfully, their granddaughter awoke from the coma.

Had she not received fluids and nutrition through a tube, she would have become dehydrated, causing her to die.

Sally and Harry decided that they want to have artificial hydration and nutrition if either of them gets in an accident or is diagnosed with a terminal illness. Because Sally works in a nursing home, she has seen how dehydration accelerates death. Sally and Harry do not want to die because of dehydration.

Artificial hydration is when a needle or tube is placed in a person's veins to provide fluid. Without fluids, a person could die within 3–14 days.

Artificial nutrition is when a tube is put in the nose, mouth, or stomach to provide food when a person is unable to eat normally.

Alzheimer's or Dementia

Sally's family has a history of Alzheimer's disease. Harry and Sally are both aware that, should Sally be diagnosed with Alzheimer's Harry will not be able to care for her properly. Both want to be sure that if Sally is unable to feed herself she has someone who can help her eat. Harry and Sally do not want food to be taken away from her if the disease cripples her. Harry and Sally both agree they want assistance with food if either of them is diagnosed with a terminal illness.

Breathing With A Machine

When Harry and Sally's granddaughter was in the coma she was on a ventilator. The ventilator enabled their granddaughter to have oxygen flowing through her lungs and to her brain.

Without the ventilator, Harry and Sally's granddaughter would have sustained more brain damage and never woken from the coma.

Harry and Sally both agree they want a ventilator if they are in an accident or diagnosed with a terminal illness. They feel a ventilator could improve conditions and may save their lives one day.

Managing Pain

Harry's sister was diagnosed with brain cancer and passed away three years ago. During her last days, Harry's sister was given pain medication to make her comfortable. Her family all agreed that having her comfortable and not in pain was the best decision while she was dying under hospice care. Harry and Sally have thought a lot about pain management. They are very aware that pain medication could have the effect of hastening their deaths or other secondary effects.

They have also talked it over with their children who expressed that they did not want to see their parents in pain. Harry and Sally's children remember how peacefully and painlessly their aunt died. Harry and Sally agree with their children. They would opt for pain medication if they are in their last days of dying.

Conclusions Oregon cannot provide you with legal advice. If you have questions when filling out an advance directive, please contact your attorney. If you need a pro-life attorney, please email us at help@conclusionsoregon.org and we can refer you.

Completing your 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 compel you to sign this document or any other of its kind.

STEP ONE

Fill out the contact information for you and your health care representative(s) requested in Sections 1 and 2 of this Advance Directive

STEP TWO

It is strongly recommended that you DO NOT complete Subsection A or Subsection B of Section 3 of this Advance Directive entitled “MY HEALTH CARE DECISIONS.” Oregon law requires Subsections A and B to be included in this document, but you do not have to fill them out. If you initial the wrong choice in Subsections A or B of Section 3, it will conflict with the pro-life language included in the document. These pages are in gray so that you know that you do not have to fill them out. The pro-life language is included as a response to the prompt at the end of Subsection A that allows you to attach pages to say more about what kind of care you want or do not want. These pages are not gray so that you know to fill them out.

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.

STEP THREE

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.

STEP FOUR

It is VERY important if you choose to identify treatments 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 page 3 for medical 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.

STEP FIVE

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.

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

OREGON ADVANCE DIRECTIVE FOR HEALTHCARE

Completing your Pro-Life
Advance Directive

1. ABOUT ME.

Name: _____ Date of Birth: _____

Telephone numbers: (Home): _____

(Cell): _____ (Work): _____

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): _____

(Cell): _____ (Work): _____

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): _____

(Cell): _____ (Work): _____

Address: _____

Email: _____

Second Alternate Health Care Representative:

Name: _____ Relationship: _____

Telephone numbers: (Home): _____

(Cell): _____ (Work): _____

Address: _____

Email: _____

Fill out the contact
information for
you and your
health care
representative(s)
requested in
Sections 1 and 2
of this Advance
Directive

3. MY HEALTH CARE INSTRUCTIONS.

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

You can provide guidance on 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. MY HEALTH CARE DECISIONS:

There are three situations 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, choose the one option that most closely fits your wishes.

a. Terminal Condition. This is what I want if:

I have an illness that cannot be cured or reversed.

AND

My health care providers believe it will result in my death within six months, regardless of any treatments.

Initial one option only:

_____ I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines

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

_____ I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.

_____ I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

b. Advanced Progressive Illness. This is what I want if:

I have an illness that is in an advanced stage.

AND

My health care providers believe it will not improve and will very likely get worse over time and result in death.

AND

My health care providers believe I will never be able to:

- Communicate
- Swallow food or water safely
- Care for myself
- Recognize my family and other people

STOP

It is strongly recommended that you **DO NOT** complete Subsection A. Oregon law requires Subsection A to be included in this document, but you do not have to fill it out.

Initial one option only:

_____ I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.

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

_____ I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.

_____ I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

c. Permanently Unconscious. This is what I want if

I am not conscious.

AND

If my health care providers believe it is very unlikely that I will ever become conscious again.

Initial one option only:

_____ I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.

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

_____ I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.

_____ I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

You may write in the space below or attach pages to say more about what kind of care you want or do not want.

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.

STOP

It is strongly recommended that you **DO NOT** complete Subsection A. Oregon law requires Subsection A to be included in this document, but you do not have to fill it out.

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 life-saving 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 life-saving treatment or care is provided to me – the following may be withheld or withdrawn:

It is VERY important if you choose to identify treatments 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.

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.

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.

IF I AM PREGNANT

If I am pregnant, I direct my health care provider(s) and health care representative to use all life-saving 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 life saving 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

B. WHAT MATTERS MOST TO ME AND FOR ME:

This section only applies when you are in a terminal condition, have an advanced progressive illness or are permanently unconscious. If you wish to use this section, you can communicate the things that are really important to you and for you. This will help your health care representative

This is what you should know about what is important to me about my life:

This is what I value the most about my life:

This is what is important for me about my life:

I do not want life-sustaining procedures if I cannot be supported and be able to engage in the following ways:

Initial all that apply.

- ☐ Express my needs.
- ☐ Be free from long-term severe pain and suffering.
- ☐ Know who I am and who I am with.
- ☐ Live without being hooked up to mechanical life support.
- ☐ Participate in activities that have meaning to me, such as:

If you want to say more to help your health care representative understand what matters most to you, write it here. (For example: I do not want care if it will result in....)

STOP

It is strongly recommended that you **DO NOT** complete Subsection B. Oregon law requires Subsection B to be included in this document, but you do not have to fill it out.

C. MY SPIRITUAL BELIEFS

Do you have spiritual or religious beliefs you want your health care representative and those taking care of you to know? They can be rituals, sacraments, denying blood product transfusions and more.

You may write in the space below or attach pages to say more about your spiritual or religious 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. LIFE AND VALUES

Below you can share about your life and values. This can 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 the space below or attach pages to say more about your life, beliefs and values.

B. PLACE OF CARE:

If there is a choice about where you receive care, what do you prefer? Are there places you want or do not want to receive care? (For example, a hospital, a nursing home, a mental health facility, an adult foster home, assisted living, your home.)

You may write in the space below or attach pages to say more about where you prefer to receive care or not receive care.

C. OTHER:

You may attach to this form other documents you think will 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 the space below.

D. INFORM OTHERS:

You can allow your health care representative to authorize your health care providers to the extent permitted by state and federal privacy laws to discuss your health status and care with the people you write in below. Only your health care representative can make decisions about your care.

Name: Relationship:

Telephone numbers: (Home):

(Cell): (Work):

Address:

Email:

Name: Relationship:

Telephone numbers: (Home):

(Cell): (Work):

Address:

Email:

Name: Relationship:

Telephone numbers: (Home):

(Cell): (Work):

Address:

Email:

Name: _____ Relationship: _____

Telephone numbers: (Home): _____

(Cell): _____ (Work): _____

Address: _____

Email: _____

6. MY SIGNATURE.

My signature: _____ Date: _____

7. WITNESS.

COMPLETE EITHER A OR B WHEN YOU SIGN.

A. NOTARY:

State of Oregon

County of _____

Signed or attested before me on this _____ day of _____, 20____,

by _____.

Notary Public – State of Oregon

My commission expires _____

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: _____

8. 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:_____

OREGON ADVANCE DIRECTIVE FOR HEALTHCARE

This Advance Directive form allows you to:

- Share your values, beliefs, goals and wishes for health care if you are 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, and they must agree to act in this role.

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 recommended that you complete this entire form.

The Oregon Advance Directive for Health Care form and Your Guide to the Oregon Advance Directive are available on the Oregon Health Authority's website.

- 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.

The Advance Directive form allows you to express your preferences for health care. It is not the same as Portable Orders for Life Sustaining Treatment (POLST) as defined in ORS 127.663. You can find more information about the POLST in Your Guide to the Oregon Advance Directive.

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 or are unable to make your own medical decisions. The person is called a health care representative. If you do not have an effective health care representative appointment and you 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) and this person can only decide to withhold or withdraw life sustaining treatments if you meet one of the conditions set forth in ORS 127.635 (1).

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:

Address:

E-mail:

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:

Address:

E-mail:

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:

Address:

E-mail:

Second Alternate Health Care Representative:

Name:

Relationship:

Telephone numbers:

Address:

E-mail:

3. MY HEALTH CARE INSTRUCTIONS.

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

You can provide guidance on 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. MY HEALTH CARE DECISIONS:

There are three situations 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, choose the one option that most closely fits your wishes.

a. Terminal Condition

This is what I want if:

- I have an illness that cannot be cured or reversed. AND

- My health care providers believe it will result in my death within six months, regard- less of any treatments.

Initial one option only:

- ___ I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.
- ___ I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.
- ___ I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.
- ___ I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

b. Advanced Progressive Illness

This is what I want if:

- I have an illness that is in an advanced stage.
- AND
- My health care providers believe it will not improve and will very likely get worse over time and result in death.

AND

- My health care providers believe I will never be able to:
 - Communicate
 - Swallow food and water safely
 - Care for myself
 - Recognize my family and other people

Initial one option only:

- ___ I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.
- ___ I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.
- ___ I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.
- ___ I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

c. Permanently Unconscious

This is what I want if:

- I am not conscious.

AND

- If my health care providers believe it is very unlikely that I will ever become conscious again.

Initial one option only:

- ___ I want to try all available treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis and breathing machines.
- ___ I want to try to sustain my life with artificial feeding and hydration with feeding tubes and IV fluids. I do not want other treatments to sustain my life, such as kidney dialysis and breathing machines.
- ___ I do not want treatments to sustain my life, such as artificial feeding and hydration with feeding tubes, IV fluids, kidney dialysis or breathing machines. I want to be kept comfortable and be allowed to die naturally.
- ___ I want my health care representative to decide for me, after talking with my health care providers and taking into account the things that matter to me. I have expressed what matters to me in section B below.

You may write in the space below or attach pages to say more about what kind of care you want or do not want.

GENERAL PRESUMPTION FOR LIFE

1. In exercising the power to make health care decisions on my behalf, my health care representative must follow my instructions.
2. 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.
3. 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.
4. I direct that medication to alleviate my pain be provided as long as the medication is not used in order to cause my death.
5. I direct that I be provided basic nursing care and procedures to provide comfort care.
6. 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.
7. 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.
8. 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.

9. 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.
10. I direct that my life not be ended by assisted suicide or euthanasia, the latter meaning an action or omission that would directly or intentionally cause my death.
11. I direct that the following be provided:
 - a. The administration of medication;
 - b. Cardiopulmonary resuscitation (CPR); and
 - c. 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 in life-saving treatment or care is providing to me – the following may be withheld or withdrawn:

- 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.
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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 only live three months or less, even if life-saving treatment or care is provided to me – the following may be withheld or withdrawn:

- 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.

IF I AM PREGNANT

If I am pregnant, I direct my healthcare provider(s) and health care representative to use all life-saving procedures for myself with none of the above special conditions applying if there's a chance that prolonging my life might allow my child to be born alive. I also direct that life-saving 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 that 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 was made to preserve both my life and the life of my unborn child.

Signature of Principal

B. WHAT MATTERS MOST TO ME AND FOR ME:

This section only applies when you are in a terminal condition, have an advanced progressive illness or are permanently unconscious. If you wish to use this section, you can communicate the things that are really important to you and for you. This will help your health care representative.

This is what you should know about what is important to me about my life:

This is what I value the most about my life:

This is what is important for me about my life:

I do not want life-sustaining procedures if I cannot be supported and be able to engage in the following ways:

Initial all that apply:

- ☐ Express my needs.
- ☐ Be free from long-term severe pain and suffering.
- ☐ Know who I am and who I am with.
- ☐ Live without being hooked up to mechanical life support.
- ☐ Participate in activities that have meaning to me, such as:

If you want to say more to help your health care representative understand what matters most to you, write it here. (For example: I do not want care if it will result in...)

C. MY SPIRITUAL BELIEFS:

Do you have spiritual or religious beliefs you want your health care representative and those taking care of you to know? They can be rituals, sacraments, denying blood product transfusions and more.

You may write in the space below or attach pages to say more about your spiritual or religious 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. LIFE AND VALUES:

Below you can share about your life and values. This can 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 the space below or attach pages to say more about your life, beliefs and values.

B. PLACE OF CARE:

If there is a choice about where you receive care, what do you prefer? Are there places you want or do not want to receive care? (For example, a hospital, a nursing home, a mental health facility, an adult foster home, assisted living, your home.)

You may write in the space below or attach pages to say more about where you prefer to receive care or not receive care.

C. OTHER:

You may attach to this form other documents you think will 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 the space below.

D. INFORM OTHERS:

You can allow your health care representative to authorize your health care providers to the extent permitted by state and federal privacy laws to discuss your health status and care with the people you write in below. Only your health care representative can make decisions about your care.

Name: _____ Relationship: _____
Telephone numbers:
(Home) _____ (Work) _____ (Cell) _____
Address: _____ E-mail: _____

Name: _____ Relationship: _____
Telephone numbers:
(Home) _____ (Work) _____ (Cell) _____
Address: _____ E-mail: _____

Name: _____ Relationship: _____
Telephone numbers:
(Home) _____ (Work) _____ (Cell) _____
Address: _____ E-mail: _____

5. MY SIGNATURE.

My signature: _____ Date: _____

6. WITNESS. COMPLETE EITHER A OR B WHEN YOU SIGN

A. NOTARY:

STATE OF OREGON)
)
County of Marion)

Signed or attested before me on this _____ .

Notary Public - State of Oregon

My commission expires _____

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 or other verification of acceptance: _____

Date: _____

Witness Name (print): _____

Signature or other verification of acceptance: _____

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: _____