

## ADVANCE DIRECTIVE FOR HEALTH CARE

I, \_\_\_\_\_, being of sound mind and eighteen (18) years of age or older, willfully and voluntarily make known my desire, by my instructions to others through my living will, or by my appointment of a health care proxy, or both, that my life shall not be artificially prolonged under the circumstances set forth below. I thus do hereby declare:

### I. LIVING WILL

a. If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act, to withhold or withdraw treatment from me under the circumstances I have indicated below by my signature. I understand that I will be given treatment that is necessary for my comfort or to alleviate my pain.

**b. If I have a terminal condition:**

(1) I direct that life-sustaining treatment shall be withheld or withdrawn if such treatment would only prolong my process of dying, and if my attending physician and another physician determine that I have an incurable and irreversible condition that even with the administration of life-sustaining treatment will cause my death within six (6) months.

Initials \_\_\_\_\_

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) that will only prolong the process of dying from an incurable and irreversible condition is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition and hydration will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition (food) and hydration (water).

Initials \_\_\_\_\_

(3) I direct that (add other medical directives, if any):

---

---

---

Initials \_\_\_\_\_

**c. If I am persistently unconscious:**

(1) I direct that life-sustaining treatment be withheld or withdrawn if such treatment will only serve to maintain me in an irreversible condition, as determined by my attending physician and another physician, in which thought and awareness of self and environment are absent.

Initials \_\_\_\_\_

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) for individuals who have become persistently unconscious is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition and hydration will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition (food) and hydration (water).

Initials \_\_\_\_\_

(3) I direct that (add other medical directives, if any):

---

---

---

Initials \_\_\_\_\_

**II. MY APPOINTMENT OF MY HEALTH CARE PROXY**

a. If my attending physician and another physician determine that I am no longer able to make decisions regarding my medical treatment, I direct my attending physician and other health care providers, pursuant to the Oklahoma Rights of the Terminally Ill or Persistently Unconscious Act, to follow the instructions of \_\_\_\_\_ whom I appoint as my health care proxy. If my health care proxy is unable or unwilling to serve, I appoint \_\_\_\_\_, as my alternate health care proxy with the same authority. My health care proxy is authorized to make whatever medical treatment decisions I could make if I were able, except that decisions regarding life-sustaining treatment can be made by my health care proxy or alternate health care proxy only as I indicate in the following sections.

**b. If I have a terminal condition:**

(1) I authorize my health care proxy to direct that life-sustaining treatment be withheld or withdrawn if such treatment would only prolong my process of dying and if my attending physician and another physician determine that I have an incurable and irreversible condition that even with the administration of life-sustaining treatment will cause my death within six (6) months.

Initials \_\_\_\_\_

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition (food) or hydration (water) will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition and hydration.

Initials \_\_\_\_\_

(3) I authorize my health care proxy to (add other medical directives, if any):

---

---

---

Initials \_\_\_\_\_

**c. If I am persistently unconscious:**

(1) I authorize my health care proxy to direct that life-sustaining treatment be withheld or withdrawn if such treatment will only serve to maintain me in an irreversible condition, as determined by my attending physician and another physician, in which thought and awareness of self and environment are absent.

Initials \_\_\_\_\_

(2) I understand that the subject of the artificial administration of nutrition and hydration (food and water) is of particular importance. I understand that if I do not sign this paragraph, artificially administered nutrition (food) and hydration (water) will be administered to me. I further understand that if I sign this paragraph, I am authorizing the withholding or withdrawal of artificially administered nutrition and hydration.

Initials \_\_\_\_\_

(3) I authorize my health care proxy to (add other medical directives, if any):

---

---

---

Initials \_\_\_\_\_

### III. ANATOMICAL GIFTS

I direct that at the time of my death my entire body or designated body organs or body parts be donated for purposes of transplantation, therapy, advancement of medical or dental science or research or education pursuant to the provisions of the Uniform Anatomical *Gift* Act. Death means either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. I specifically donate:

My entire body; or

• The following body organs or parts: check all that apply.

- |  |   |                                   |  |
|--|---|-----------------------------------|--|
| <input type="checkbox"/> Arteries      | <input type="checkbox"/> Eyes/Cornea/Lens | <input type="checkbox"/> Liver    | <input type="checkbox"/> Tissue          |
| <input type="checkbox"/> Brain         | <input type="checkbox"/> Glands           | <input type="checkbox"/> Lungs    | <input type="checkbox"/> Other - SPECIFY |
| <input type="checkbox"/> Bloods/Fluids | <input type="checkbox"/> Heart            | <input type="checkbox"/> Pancreas | _____                                    |
| <input type="checkbox"/> Bones/Marrow  | <input type="checkbox"/> Kidneys          | <input type="checkbox"/> Skin     | _____                                    |

Initials \_\_\_\_\_

### IV. CONFLICTING PROVISION

I understand that if I have completed both a living will and have appointed a health care proxy, and if there is a conflict between my health care proxy's decision and my living will, my living will shall take precedence unless I indicated otherwise:

---

---

---

Initials \_\_\_\_\_

**V. GENERAL PROVISIONS**

a. I understand that if I have been diagnosed as pregnant and that diagnosis is known to my attending physician, this advance directive shall have no force or effect during the course of my pregnancy.

b. In the absence of my ability to give directions regarding the use of life-sustaining procedures, it is my intention that this advance directive shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment including, but not limited to, the administration of any life-sustaining procedures, and I accept the consequences of such refusal.

c. This advance directive shall be in effect until it is revoked.

d. I understand that I may revoke this advance directive at any time.

e. I understand and agree that if I have any prior directives, and if I sign this advance directive, my prior directives are revoked.

f. I understand the full importance of this advance directive and I am emotionally and mentally competent to make this advance directive.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

Signature \_\_\_\_\_

\_\_\_\_\_  
City, County and State of Residence

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

This advance directive was signed in my presence.

This advance directive was signed in my presence

\_\_\_\_\_  
Signature - Witness #1

\_\_\_\_\_  
Signature - Witness #2

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City - State - Zip Code

\_\_\_\_\_  
City - State - Zip Code