

Pennsylvania Living Will Health Care Treatment Instructions

INTRODUCTORY REMARKS ON HEALTH CARE DECISION MAKING

You have the right to decide the type of health care you want. Should you become unable to understand, make or communicate decisions about medical care, your wishes for medical treatment are most likely to be followed if you express those wishes in advance by giving health care treatment instructions to your health care agent or health care provider.

An advance health care directive is a written set of instructions expressing your wishes for medical treatment. It may contain a living will, where you tell your health care providers your choices regarding the initiation, continuation, withholding or withdrawal of life-sustaining treatment and other specific directions.

A living will cannot be followed unless your attending physician determines that you lack the ability to understand, make or communicate health care decisions for yourself and you are either permanently unconscious or you have an end-stage medical condition, which is a condition that will result in death despite the introduction or continuation of medical treatment.

If you do not write down your wishes about your health care in advance, and if later you become unable to understand, make or communicate these decisions, those wishes may not be honored because they may remain unknown to others.

A health care provider who refuses to honor your wishes about health care must tell you of its refusal and help to transfer you to a health care provider who will honor your wishes.

You should give a copy of your advance health care directive (living will) to your physicians, family members and others whom you expect would likely attend to your needs if you become unable to understand, make or communicate decisions about medical care.

If your health care wishes change, tell your physician and write a new advance health care directive to replace your old one.

You may wish to consult with knowledgeable, trusted individuals such as family members, your physician or clergy when considering an expression of your values and health care wishes. You are free to create your own advance health care directive to convey your wishes regarding medical treatment. The following form is an example of an advance health care directive (living will).

NOTES ABOUT THE USE OF THIS FORM

If you decide to use this form or create your own advance health care directive, you should consult with your physician and your attorney to make sure that your wishes are clearly expressed and comply with the law.

If you decide to use this form but disagree with any of its statements, you may cross out those statements. You may add comments to this form or use your own form to help your physician or health care agent decide your medical care.

If you are a woman and diagnosed as being pregnant at the time a health care decision would otherwise be made pursuant to this form, the laws of this Commonwealth prohibit implementation of that decision if it directs that life-sustaining treatment, including nutrition and hydration, be withheld or withdrawn from you, unless your attending physician and an obstetrician who have examined you certify in your medical record that the life-sustaining treatment:

- (1) will not maintain you in such a way as to permit the continuing development and live birth of the unborn child;
- (2) will be physically harmful to you; or
- (3) will cause pain to you that cannot be alleviated by medication.

A physician is not required to perform a pregnancy test on you unless the physician has reason to believe that you may be pregnant.

Pennsylvania law protects your health care providers from any legal liability for following in good faith your wishes as expressed in the form. It does not otherwise change professional standards or excuse negligence in the way your wishes are carried out. If you have any questions about the law, consult an attorney for guidance.

This form and explanation is not intended to take the place of specific legal or medical advice for which you should rely upon your own attorney and physician.

HEALTH CARE TREATMENT INSTRUCTIONS
IN THE EVENT OF END-STAGE MEDICAL CONDITION
OR PERMANENT UNCONSCIOUSNESS

The following health care treatment instructions exercise my right to make my own health care decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make or communicate my treatment decisions:

IF I HAVE AN END-STAGE MEDICAL CONDITION (WHICH WILL RESULT IN MY DEATH, DESPITE THE INTRODUCTION OR CONTINUATION OF MEDICAL TREATMENT) OR AM PERMANENTLY UNCONSCIOUS SUCH AS AN IRREVERSIBLE COMA OR AN IRREVERSIBLE VEGETATIVE STATE AND THERE IS NO REALISTIC HOPE OF SIGNIFICANT RECOVERY, ALL OF THE FOLLOWING APPLY (CROSS OUT ANY TREATMENT INSTRUCTIONS WITH WHICH YOU DO NOT AGREE):

1. I direct that I be given health care treatment to relieve pain or provide comfort even if such treatment might shorten my life, suppress my appetite or my breathing, or be habit forming.
2. I direct that all life prolonging procedures be withheld or withdrawn.
3. I specifically do not want any of the following as life prolonging procedures:

(If you wish to receive any of these treatments, write "I do want" after the treatment)

heart-lung resuscitation (CPR) _____
mechanical ventilator (breathing machine) _____
dialysis (kidney machine) _____
surgery _____
chemotherapy _____
radiation treatment _____
antibiotics _____

Please indicate whether you want nutrition (food) or hydration (water) medically supplied by a tube into your nose, stomach, intestine, arteries, or veins if you have an end-stage medical condition or are permanently unconscious and there is no realistic hope of significant recovery.

(Initial only one statement.)

TUBE FEEDINGS

_____ I want tube feedings to be given
OR

NO TUBE FEEDINGS

_____ I do not want tube feedings to be given.

HEALTH CARE AGENT'S USE OF INSTRUCTIONS

(Initial only one statement.)

_____ My health care agent must follow these instructions.

OR

_____ These instructions are only guidance.

My health care agent shall have final say and may override any of my instructions.
(Indicate any exceptions)

If I did not appoint a health care agent, these instructions shall be followed.

LEGAL PROTECTION

Pennsylvania law protects my health care providers from any legal liability for their good faith actions in following my wishes as expressed in this form. On behalf of myself, my executors and heirs, I further hold my health care providers harmless and indemnify them against any claim for their good faith actions in following my treatment instructions.

ORGAN DONATION (INITIAL ONE OPTION ONLY.)

_____ I consent to donate my organs and tissues at the time of my death for the purpose of transplant, medical study or education. (Insert any limitations you desire on donation of specific organs or tissues or uses for donation of organs and tissues.)

OR

_____ I do not consent to donate my organs or tissues at the time of my death.

Having carefully read this document, I have signed it this ____ day of _____, 20__, revoking all previous health care powers of attorney and health care treatment instructions.

Signed: _____

(SIGN FULL NAME HERE FOR HEALTH CARE TREATMENT INSTRUCTIONS)

Witness _____

Witness _____

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on

behalf of and at the direction of a principal may not be a witness. (It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your health care providers.)

NOTARIZATION (OPTIONAL)

(Notarization of document is not required by Pennsylvania law, but if the document is both witnessed and notarized, it is more likely to be honored by the laws of some other states.)

On this this ____ day of _____, 20 __, before me personally appeared the aforesaid declarant and principal, to me known to be the person described in and who executed the foregoing instrument and acknowledged that he/she executed the same as his/her free act and deed.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal in the County of _____, State of _____, the day and year first above written.

Notary Public

My Commission Expires: _____