~ Oregon ~

Advance Directive
Christian Version

PART A: IMPORTANT INFORMATION ABOUT THIS ADVANCE DIRECTIVE

This is an important legal document. It can control critical decisions about hour health care. Before signing, consider these important facts:

FACTS ABOUT PART B (APPOINTING A HEALTH CARE REPRESENTATIVE)

You have the right to name a person to direct your health care when you cannot do so. This person is called your "health care representative." You can do this by using Part B of this form. Your representative must accept on Part E of this form.

You can write in this document any restrictions you want on how your representative will make decisions for you. Your representative must follow your desires as stated in this document or otherwise made known. If your desires are unknown, your representative must try to act in your best interest. Your representative can resign at any time.

FACTS ABOUT PART C (GIVING HEALTH CARE INSTRUCTIONS)

You also have the right to give instructions for health care providers to follow if you become unable to direct your care. You can do this by using Part C of this form.

FACTS ABOUT COMPLETING THIS FORM

This form is valid only if you sign it voluntarily and when you are of sound mind. If you do not want an advance directive, you do not have to sign this form.

Unless you have limited the duration of this advance directive, it will not expire. If you have set an expiration date, and you become unable to direct your health care before that date, this advance directive will not expire until you are able to make those decisions again.

You may revoke this document at any time. To do so, notify your representative and your health care provider of the revocation.

Despite this document, you have the right to decide your own health care as long as you are able to do so. If there is anything in this document that you do not understand, ask a lawyer to explain it to you.

You may sign PART B, PART C, or both parts. You may cross out words that don't express your wishes. Witnesses must sign PART D.

STATE OF OREGON ADVANCE DIRECTIVE

Written in accordance with Oregon Revised Statutes § 127.531

Print your NAME, BIRTHDATE, AND ADDRESS here:

Name: ______________________________ **Birth Date:** ______________
(Print Your Name)

Address: ____

____

Unless revoked or suspended, this advance directive will continue for:

INITIAL ONE: _______ My entire life _______ Other period (________ Years)

PART B: APPOINTMENT OF HEALTH CARE REPRESENTATIVE

I appoint ______________________________ as my health care representative.
(Name of health care representative)

My representative's address is ______________________________

and telephone number is (______) __________________. I appoint ______________________
(Name of alternate health care representative)

as my alternate health care representative. My alternate's address is ______________________
(Address)

______________________ and telephone number is (_____) __________________.

I authorize my representative (or alternate) to direct my health care when I cannot do so.

NOTE: You may not appoint your doctor, an employee of your doctor, or an owner, operator, or employee of your health care facility, unless that person is related to you by blood, marriage, or adoption or that person was appointed before your admission into the health care facility.

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1. **LIMITS.**

   SPECIAL CONDITIONS OR INSTRUCTIONS: ______________________________________

   ____

   ____

   ____

   ____

   ____

   INITIAL IF THIS APPLIES:
   [______] I have executed a Health Care Instruction (Part C – Page 4) or Directive to Physicians. My representative is to honor it.

2. **LIFE SUPPORT.**
   "Life support" refers to any medical means for maintaining life, including procedures, devices and medications. If you refuse life support, you will still get routine measures to keep you clean and comfortable.

   INITIAL IF THIS APPLIES:
   [______] My representative MAY decide about life support for me. (If you don't initial this space, then your representative MAY NOT decide about life support.)

3. **TUBE FEEDING.**
   One sort of life support is food and water supplied artificially by medical device, known as tube feeding.

   INITIAL IF THIS APPLIES:
   [______] My representative MAY decide about tube feeding for me. (If you don't initial this space, then your representative MAY NOT decide about tube feeding.)

Date: ____

SIGN HERE TO APPOINT A HEALTH CARE REPRESENTATIVE

____

(Signature of person making appointment)

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PART C: HEALTH CARE INSTRUCTIONS

NOTE: In filling out these instructions, keep the following in mind:

The term "as my physician recommends" means that you want your physician to try life support and then discontinue it if it is not helping your health condition or symptoms.

"Life support" and "tube feeding" are defined in Part B above.

If you refuse tube feeding, you should understand that malnutrition, dehydration and death will probably result.

You will get care for your comfort and cleanliness, no matter what choices you make.

You may either give specific instructions by filling out Items 1 to 4 below, or you may use the general instruction provided by Item 5.

Here are my desires about my health care if my doctor and another knowledgeable doctor confirm that I am in a medical condition described below:

1. CLOSE TO DEATH.

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

A. INITIAL ONE:

____ I want to receive tube feeding.
____ I want tube feeding only as my physician recommends.
____ I DO NOT WANT tube feeding.

B. INITIAL ONE:

____ I want any other life support that may apply.
____ I want life support only as my physician recommends.
____ I want NO life support.

2. PERMANENTLY UNCONSCIOUS.

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

A. INITIAL ONE:

____ I want to receive tube feeding.
____ I want tube feeding only as my physician recommends.
____ I DO NOT WANT tube feeding.

B. INITIAL ONE:

____ I want any other life support that may apply.
____ I want life support only as my physician recommends.
____ I want NO life support.

3. ADVANCED PROGRESSIVE ILLNESS.

If I have a progressive illness that will be fatal and the illness is in an advanced stage, and I am consistently and permanently unable to communicate, 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:

A. INITIAL ONE:

I want to receive tube feeding.
____ I want tube feeding only as my physician recommends.
____ I DO NOT WANT tube feeding.

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B. INITIAL ONE:

_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want NO life support.

4. EXTRAORDINARY SUFFERING.

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

A. INITIAL ONE:

_____ I want to receive tube feeding.
_____ I want tube feeding only as my physician recommends.
_____ I DO NOT WANT tube feeding.

B. INITIAL ONE:

_____ I want any other life support that may apply.
_____ I want life support only as my physician recommends.
_____ I want NO life support.

5. GENERAL INSTRUCTION.

INITIAL IF THIS APPLIES:

_____ 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 doctors to allow me to die naturally if my doctor and another knowledgeable doctor confirm I am in any of the medical conditions listed in Items 1 to 4 above.

6. ADDITIONAL CONDITIONS OR INSTRUCTION.

(Insert description of what you want done.)

____

____

____

____

(Attach additional pages, if needed)

7. OTHER DOCUMENTS.

A "health care power of attorney" is any document you may have signed to appoint a representative to make health care decisions for you.

INITIAL ONE:

_____ I have previously signed a health care power of attorney. I want it to remain in effect unless I appointed a health care representative after signing the health care power of attorney.
_____ I have a health care power of attorney, and I REVOKE IT.
_____ I DO NOT have a health care power of attorney.

Date: ______________________________________

SIGN HERE TO GIVE INSTRUCTIONS

____
(Signature)

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PART D: DECLARATION OF WITNESSES

NOTE: One witness must not be a relative (by blood, marriage, or adoption) of the person signing this advance directive. That witness must also not be entitled to any portion of the person's estate upon death. That witness must also not own, operate, or be employed at the health care facility where the person is a patient or resident.

We declare that the person signing this advance directive:

(a) Is personally known to us or has provided proof of identity;
(b) Signed or acknowledged that person's signature on this advance directive in our presence;
(c) Appears to be of sound mind and not under duress, fraud, or undue influence;
(d) Has not appointed either of us as health care representative or alternative representative; and
(e) Is not a patient for whom either of us is attending physician.

Witnessed by:

______________________________ _______________
(Signature of witness) (Date)

____
(Printed name of witness)

______________________________ _______________
(Signature of witness) (Date)

____
(Printed name of witness)

PART E: ACCEPTANCE BY HEALTH CARE REPRESENTATIVE

I accept this appointment and agree to serve as health care representative. I understand I must act consistently with the desires of the person I represent, as expressed in this advance directive or otherwise made known to me. I understand that this document allows me to decide about that person's health care only while that person cannot do so. I understand that the person who appointed me may revoke this appointment. If I learn that this document has been suspended or revoked, I will inform the person's current health care provider if known to me. If I do not know the desires of the person I represent, I have a duty to act in what I believe in good faith to be that person's best interest.

______________________________ _______________
(Signature of health care representative) (Date)

____
(Printed name)

______________________________ _______________
(Signature of alternate health care representative) (Date)

____
(Printed name)

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ADDENDUM TO THE STATE OF OREGON ADVANCE DIRECTIVE

GENERAL STATEMENT OF AUTHORITY GRANTED

Unless I have specified otherwise in this document, if I ever have incapacity I instruct my health care provider to obtain the health care decision of my health care representative, if I need treatment, for all of my health care and treatment. I have discussed my desires thoroughly with my health care representative and believe that he or she understands any philosophy regarding the health care decisions I would make if I were able. I desire that my wishes be carried out through the authority given to my health care representative under this document.

If I am unable, due to my incapacity, to participate in making a health care decision, my health care representative is instructed to make the health care decision for me, but my health care representative should try to discuss with me any specific proposed health care if I am able to communicate in any manner, including by blinking my eyes. If this communication cannot be made, my health care representative shall base his or her decision on any health care choices that I have expressed prior to the time of the decision. If I have not expressed a health care choice about the health care in question and communication cannot be made, my health care representative shall base his or her health care decision on what he or she believes to be in my best interest.

MY HEALTH CARE STATEMENT OF BELIEFS

My philosophy regarding the health care decisions I would make, if I were able to participate in medical treatment decisions, is based on my belief in the inherent value of human life and that life is a gift from God. It is my desire that all reasonable efforts be made to sustain my life and health.

I believe that death is the normal end of earthly life, and that God takes life by his decision. Therefore, I reject any attempt to end my life when God would sustain it, regardless of any diminished state of quality to my life, even if I have a disability. Similarly, I reject any attempt to lengthen my life when it is clear God intends to take it.

I believe life begins at conception. Therefore, if I have been diagnosed as pregnant and my physician knows of this diagnosis, I request that every effort be made to save the life of my unborn child in full recognition that two lives are at stake, both equal in value and worthy of protection.

HEALTH CARE DIRECTIVES

1. I direct my health care representative to consent to the following health care:
   a. Health care that is intended to relieve pain or to make me comfortable.
   b. Health care to cure or improve any physical or mental condition which can be cured or improved. This includes health care that is intended to be used temporarily or because it is potentially effective.

2. My health care representative has no authority to consent to any act or omission intended to cause or hasten my death.

3. I instruct my health care representative to ensure that my attending physician and other health care providers provide my health care based on my health care philosophy and my health care directives as set forth in this document.

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4. Should it become clear that God wishes to take my life, namely that I am diagnosed to have a terminal illness or injury where death is imminent, I direct that life–sustaining procedures be withheld or withdrawn, and that I be permitted to die in God's time. I do *not* give consent for the withholding or withdrawal of nutrition or hydration, even if I am diagnosed to have a terminal illness or injury, if doing so would cause my death by starvation or dehydration rather than from the terminal condition or injury.

5. If God allows the quality of my life to be diminished but gives me strength to continue living for an indeterminate amount of time, I request that reasonable care be administered to me to sustain my life and ease discomfort as much as possible.

EXCEPTIONS TO HEALTH CARE DIRECTIVES

1. My health care representative may refuse consent to health care that would not be effective in terms of my survival.

2. If I have an incurable terminal illness or injury where I am in the final stages of dying, and it is medically certain that my death with occur within hours or a few days, my health care representative may consent to the withholding or withdrawal of any health care that is not intended to relieve pain or make me comfortable.

3. If I have an incurable terminal illness or injury, and it is medically certain that my death will occur within six (6) months, my health care representative may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

4. If I have a total, chronic, and irreversible loss of consciousness, and this condition has been diagnosed with medical certainty by two physicians, one of whom is my attending physician and the other is an expert in diagnosing my condition, my health care representative may consent to the withholding or withdrawal of life–sustaining health care. However, I still desire health care for easily treatable acute and chronic conditions, and health care that is intended to relieve pain or make me comfortable.

NUTRITION AND HYDRATION

Food and fluids

1. I believe that nutrition and hydration are basic human needs which should be provided to me even though providing them may require medical expertise and technology.

2. If I have initialed "My representative MAY decide about a feeding tube for me" (on page 3), then a feeding tube may only be withheld or withdrawn from me if:
    a. I have an incurable terminal illness or injury where I am in the final stage of dying, and it is medically certain that my death will occur within hours or a few days, and
    b. The withholding or withdrawal of the feeding tube would not result in my death from malnutrition or dehydration, or complications of malnutrition or dehydration, rather than from my underlying terminal illness or injury.

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PREGNANT WOMEN

If I am pregnant, the following applies:

1. My health care representative is authorized to make health care decisions on behalf of my unborn child as an individual patient.

2. Health care necessary to sustain the life or health of my unborn child should be provided unless it is medically certain that my unborn child would not survive even if the health care were provided.

3. It is my desire that all reasonable efforts be made to sustain both my life and health and the life and health of my unborn child.

4. Even if I have an incurable illness or injury, or I am legally determined to be brain dead, it is my desire to receive all health care, to remain on any necessary life support systems, and to receive nutrition and hydration until my unborn child can sustain life apart from my body, unless it is medically certain that my unborn child would not survive even if I receive such health care.

5. No one is authorized to consent to an abortion for me unless it is directly and medically necessary to prevent my death.

HEALTH CARE DECISIONS FOR PREGNANT WOMEN

If I have checked "Yes" to the following, my health care representative may make health care decisions for me even if my agent knows I am pregnant. If I have checked "No" to the following, my health care representative may not make health care decisions for me if my health care representative knows I am pregnant.

Health care decision if I am pregnant: **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my health care representative may not make health care decisions for me if he or she knows I am pregnant.

In no event is my health care representative authorized to make medical treatment decisions to withhold or withdraw treatment for me if I am pregnant that would result in my death.

LIMITATIONS ON MENTAL HEALTH TREATMENT

My health care representative may not admit or commit me on an inpatient basis to an institution for mental diseases, a state treatment facility, or a treatment facility. My health care representative may not consent to experimental mental health research or psychosurgery, electroconvulsive treatment, or drastic mental health treatment procedures for me.

INSPECTION AND DISCLOSURE OF INFORMATION RELATING TO MY PHYSICAL OR MENTAL HEALTH

Subject to any limitations in this document, my health care representative has the authority to do all of the following:

1. Request, review and receive any information, verbal or written, regarding my physical or mental health, including medical and hospital records.

2. Execute on my behalf any documents that may be required in order to obtain this information.

3. Consent to the disclosure of this information.

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HIPAA RELEASE STATEMENT

I intend for my health care agent to be treated as I would with respect to my rights regarding the use and disclosure of my individual protected health information or other medical records. I grant to my agent the right to receive, disclose, or release, without restriction, all of my protected health information. This release statement applies to any information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

ADMISSION TO NURSING HOMES

My health care representative may admit me to a nursing home for short–term stays for recuperative care or respite care.

If I have checked "Yes" to the following, my health care representative may admit me for a purpose other than recuperative care or respite care, but if I have checked "No" to the following, my health care representative may not so admit me:

A nursing home: **Yes** ❑ **No** ❑

If I have not checked either "Yes" or "No" immediately above, my health care representative may only admit me for short–term stays for recuperative care or respite care.

STATEMENT OF DESIRES, SPECIAL PROVISIONS, OR LIMITATIONS

In exercising authority under this document, my health care representative shall act consistently with my following stated desires, if any, and is subject to any special provisions or limitations that I specify. The following are any specific desires, provisions, or limitations that I wish to state (add more items as appropriate):

1. I request that the Addendum be included as a valid part of this Advance Directive for Health Care document.

2. I request, but not as a requirement, that my health care representative consult my clergy regarding health care decisions.

3. ____

____

____

____

____

____

[Attach additional pages, if necessary.]

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ANATOMICAL GIFTS

Optional

Upon my death:

_______ I wish to donate only the following organs or parts:

____

____

____

____

____

_______ I wish to donate any needed organ or part.

_______ I wish to donate my body for anatomical study if needed.

_______ I refuse to make an anatomical gift. (If this revokes a prior commitment that I have made to make an anatomical gift to a designated donee, I will attempt to notify the donee to which or to whom I agreed to donate.)

Failure to check any of the lines immediately above creates no presumption about my desire to make or refusal to make an anatomical gift.

Signature: ____ Date: ______________________

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The principal and the witnesses must sign the document at the same time.

SIGNATURE OF PRINCIPAL

(Person creating this Advance Directive)

Signature: ____ Date: __________________________

(The signing of this document by the principal revokes all previous advance directive for health care documents.)

DECLARATION OF WITNESSES

We declare that the principal is personally known to us, that the principal signed or acknowledged the principal's signature on this Advance Directive in our presence, that the principal appears to be of sound mind and not under duress, fraud, or undue influence, that neither of us is the person appointed as health care representative by this document or the principal's attending physician.

Witnessed By:

Signature of witness: ____________________________________ Date: _______/_____/___________

Printed name: ____

Signature of witness: ____________________________________ Date: _______/_____/___________

Printed name: ____

ACCEPTANCE OF APPOINTMENT OF POWER OF ATTORNEY

I accept this appointment and agree to serve as health care representative for health care decisions. I understand I have a duty to act consistently with the desires of the principal as expressed in this appointment. I understand that this document gives me authority over health care decisions for the principal only if the principal becomes incapable. I understand that I must act in good faith in exercising my authority under this advance directive. I understand that the principal may revoke this power of attorney at any time in any manner, and that I have a duty to inform the principal's attending physician promptly upon any revocation.

Signature of health
care representative: ____________________________________ Date: _______/_____/___________

Printed name: ____

Signature of alternate
health care representative:________________________________ Date: _______/_____/___________

Printed name: ____

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CLERGY

Optional

The principal has requested that the agent consult me, as the principal's clergy, regarding any health care decisions. I understand that this request has been made and am willing to work with the health care representative to help meet the directives as described in this Advance Directive document and attached Addendum.

Clergy's signature: ____ Phone: (_____) __________________

Church address: ____

I have given copies of this Advance Directive – Christian Version to:

____

____

____

____

____

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